Eastman Dental Care Medical History Form

Patient:
First Name:_____ M.I.__ Last Name:_____ Preferred Name _____
Street: _____ City:_____ State: _____ Zip:_____
Home Phone: (___)_____ Cell Phone: (___)_____ Employer:_____
Work Phone: (___)_____ Ext._____ Email:_____
SSN:_____ Sex: Male☐ Female☐ Date of Birth:_____

Who will be responsible for your account? - *the responsible party must be present to sign this section. We cannot list someone other than yourself if that person is not with you today.*
First Name: _____ M.I.__ Last Name: _____ Preferred Name:_____
Street: _____ City: _____ State: _____ Zip:_____
Home Phone: (___)_____ Cell Phone: (___)_____ Employer:_____
Work Phone: (___)_____ Ext._____ Email:_____
SSN:_____ Sex: Male☐ Female☐ Age:_____ Marital Status:_____
Responsible Party Signature: _____ Date:_____

Primary Dental Insurance Company:
Insurance Company Name:_____
Policy Number: _____ Group Number:_____
Customer Service Phone: _____
Name of Policy Holder:_____ DOB:_____ Sex: Male☐ Female☐
Street: _____ City:_____ State: _____ Zip:_____
SSN:_____ Telephone:_____ Employer: _____

Secondary Dental Insurance Company:
Insurance Company Name:_____
Policy Number: _____ Group Number:_____
Customer Service Phone: _____
Name of Policy Holder:_____ DOB:_____ Sex: Male☐ Female☐
Street: _____ City:_____ State: _____ Zip:_____
SSN:_____ Telephone:_____ Employer: _____

How did you hear about us?
☐Facebook ☐Instagram ☐Google ☐Website ☐Flyer ☐Friend or Family_____
Why did you choose us to be your dental provider?_____
_____

X Date:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the incorrect information can be dangerous for heath. It is my responsibility to inform the dental office of any changes in medical status.

Eastman Dental Care Medical History Form

Name:

How are you doing today?
Is there anything you'd like to share with Eastman Dental Care?

❶Do you have a Primary Care Physician?
_____

❷Have you ever been hospitalized or had a major operation? _____
_____

❸Have you ever had a serious head or neck injury?
_____

❹Are you taking any medications, pills, or drugs?
☐ _____
☐ _____
☐ _____
☐ _____

❺Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No

❻Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
☐Yes ☐No

❼Do you use tobacco?
☐Yes ☐No

Are you allergic to any of the following?

☐Aspirin
☐Penicillin
☐Codeine
☐Acrylic
☐Other: _____
☐Metal
☐Latex
☐Sulfa Drugs
☐Local Anesthetics

Women: Are you….
☐Trying to get pregnant?
☐Nursing?
☐Taking Oral Contraceptives

Do you have, or have you had any of the following?

☐AIDS/HIV Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Breathing Problems
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores/ Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Heart/Attack
☐Heart Murmur
☐Heart Pacemaker
☐Heart Trouble/Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐High Cholesterol
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver Disease
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve
☐Osteoporosis
☐Pain in Jaw Joints
☐Parathyroid Disease
☐Psychiatric Care
☐Radiation Treatment
☐Recent Weight Loss
☐Renal Disease
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach/Intestinal Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumor of Growths
☐Ulcers
☐Venereal Disease

Phone: _____
Email: _____

X _____ Date: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the incorrect information can be dangerous for heath. It is my responsibility to inform the dental office of any changes in medical status.

Eastman Dental Care Financial Agreement

Acknowledgment of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Eastman Dental Notice of Privacy Practices. Eastman Dental Care is permitted to revise its Notice of Privacy at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you were offered and/or given a copy of Eastman Dental Care's Notice of Privacy Practices.

Patient Name: _____

Patient Representative (if patient is a minor or unable to sign for themselves) and their authority act on behalf the patient.

Signature: _____ Relationship: _____

Please list the name(s) of the individual(s) with whom we are allowed verbal discussion regarding dental and/ or financial information.

Name(s): _____ Relationship: _____ ☐ Dental ☐ Financial
Name(s): _____ Relationship: _____ ☐ Dental ☐ Financial
Name(s): _____ Relationship: _____ ☐ Dental ☐ Financial
Name(s): _____ Relationship: _____ ☐ Dental ☐ Financial
Name(s): _____ Relationship: _____ ☐ Dental ☐ Financial

I understand it is my responsibility to contact Eastman Dental Care of any changes (e.g. divorce, etc.)

Neglecting to inform Eastman Dental Care of any changes to this list could result in your dental information being shared against your wishes. Not updating this list could result in Eastman Dental Care not being allowed to give information to an individual you would like to have involved in your care.

X _____ Date: _____

Eastman Dental Care Financial Agreement

Payment for Service:

Payment for procedures can be completed with a check, cash, credit card or insurance payment. Payment is due in full on day of service. If you have questions about your payment responsibilities, please call our office at 319.339.4456. Ninety days after the closing date there will be a financing charge of 1.5% per month (18% per year). Minimum monthly charge of $2.00. A return check fee of $30 will be added for any returned checks.

Insurance:

Patient is responsible for being aware of what benefits are available with their insurance company. We will not be responsible for coordination of benefits between primary and secondary insurances. If you want us to file your insurance on your behalf, we need complete information from you at the time of service, otherwise payment is due in full at the time of service.

Eastman Dental Care will request payment on the day of service based on a percentage we have calculated on prior experience with your insurance group/ or any information on benefits we can attain prior to service. Our staff can only provide a courtesy estimate. We will send any documentation needed or explanation of any type of procedure to process your claim. We will assist you with you claim, but it is your responsibility to pursue unpaid claims promptly. If the insurance does not process the claim within 90 days you will be responsible for this amount. Often there are special circumstances where there is more than one insurance to process, or additional information is needed etc. and we will allow more time in order for the claim to process.

I hereby authorize the payment of insurance benefits directly to the office of Eastman Dental Care. I realize that I am financially responsible to this off for all charges not covered by this agreement.

Cancellation Policy:

To promote efficient access to our clinic, we require that any appointment that is no longer needed or is unable to be kept, must be cancelled at least 24 hours in advance of the appointment. Cancellations must be made during normal business hours on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals. Patients will not be charged if cancellation is made 24 business hours before their appointment.
Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 24 hours' notice, or no notice, a $75 charge will be billed. If a third no-show or same day cancellation on occurs, we reserve the right to terminate the doctor-parent relationship as well as another

Agreement:

I agree to pay the amount charged by Eastman Dental Care for all professional treatment and service. If the fee for service is not paid within 90 days, I agree to pay all cost of collections, including, but not limited to, reasonable attorney fees.

X _____ Date: _____