ETERNITY DENTAL

*PLEASE PRINT LEGIBLY*

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

## PERSONAL

**Patient** Name_____
Last First MI (Preferred)

Birthdate _____ SS#_____ DL# _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____Email_____

***If patient is under 18 yrs, please also complete the following:***

***Guarantor** Name*_____
Last First MI (Preferred)

*Birthdate*_____ *SS#*_____ *DL#* _____ *Gender: [ ] M [ ] F Married: [ ] Y [ ] N*

Work Phone_____ Wireless Phone_____Email_____

Preferred contact method [ ] Hm Phone [ ] Wk Phone [ ] Wireless Ph [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Part time

How did you hear about us? (Please be specific so we can thank them!) _____

## ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

## INSURANCE POLICY 1

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Sub. Name _____ Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

## FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance, and receive payment directly from them.
* We ask that you inform us at least 24 hours notice to reschedule your appointment. No shows are charged $25.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

## MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

[ ]NONE

_____

_____

_____

_____

Check medications or drugs you are allergic to:

[ ]NONE

[ ] Aspirin
[ ] Codeine/ Other Narcotics
[ ] Erythromycin
[ ] Latex Rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Other: _____

Check any medical conditions you may have:

[ ]NONE

[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia/Leukemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Blood Clotting Problems
[ ] Blood Transfusion
[ ] Bronchitis
[ ] Cancer/Tumor or Growth
[ ] Cardiac Pacemaker
[ ] Chest Pain Upon Exertion
[ ] Damage Heart Valve
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells/Seizures
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequently Dry Mouth/Sjogren
[ ] Gall Bladder Trouble
[ ] Heart Attack/Stroke
[ ] Heart Disease/Angina
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement, Date of: _____
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistent Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Other: _____

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit:_____ Are you in pain? Yes / No

**WOMEN: Are you currently pregnant? Y / N If yes, when are you expecting?_____**

**New patients:**

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Name (printed) Date

## Health Insurance Portability & Accountability Act-HIPAA

I, understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (next page).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Eternity Dental has the right to change its Notice of Privacy Practices from time to time and that I may contact Eternity Dental at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Eternity Dental restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Eternity Dental is not required to agree to my requested restrictions, but if Eternity Dental does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Eternity Dental has taken action relying on this consent.

By signing your first name and last name, you certify that you have received and read this organization Notice of Privacy Practices (next page).

_____ _____

Patient/Guardian Name (printed) Date

## Dental Service Agreement

I hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate. I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____ _____

Patient/Guardian Name (printed) Date

ETERNITY DENTAL

# Broken Appointment Policy

****Please be aware of our 24-hour cancelation policy. ****

Same day cancelations, no call/no shows and a canceled appointment without sufficient notice are considered broken appointments. For broken appointments there will be a

**25.00 dollar non-refundable fee.**

Broken appointments result in a loss of valuable time that could be spent with patients in need of treatment since a specific time is reserved for the patient to see the dentist.

We understand that sometimes a patient is unable to make a scheduled appointment due to unforeseen circumstances. If you need to cancel your appointment call, text, or email us at least 24 hours in advance. We can be reached at (972)542 4402 or via our email info@eternity.dental.

If you have scheduled a preferred time and do not keep your appointment, we cannot guarantee we will be able to give you that time again. Thank you for your anticipated cooperation!

Signature Date

## Who can we thank for your visit with us today?

□ Drive/ Walk by

□ Insurance Company

□ Transfer from another dental office

□ Patient Referral: _____

□ Online Search

□ Mailer

□ Staff

□ Other: _____

## Are there any particular issues or services you would like to discuss?

□ Toothache/ Pain

□ Removal of Wisdom Teeth

□ Bridge/ Partials/ Dentures

□ Teeth Whitening

□ Gum Bleeding/ Pain

□ Chipped or Cracked Teeth

□ Invisalign/ Braces

□ Implants

□ Other: _____