TIME 08:30 AM

DATE 10/3/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Contact #

Referred By

Previous Dentist

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 8:31 AM

John M. Fox, DDS

Eaglesoft Medical History

Date 10/3/2018

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Question			
Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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

Signature of Patient, Parent or Guardian:

X

Date:__________

DENTAL HEALTH INFORMATION

Thank you for providing us with Important Information that will help us serve you better.

Are you having any discomfort? ☐ yes ☐ no

Any sensitivity to hot, cold, sweets, chewing? ☐ yes ☐ no

Does dental treatment make you nervous? ☐ yes ☐ no

Have you experienced any of the following problems?

- Bleeding gums ☐ yes ☐ no
- Bad breath ☐ yes ☐ no
- Soreness in jaw joint ☐ yes ☐ no
- Grinding your teeth ☐ yes ☐ no
- Snoring ☐ yes ☐ no

On a scale of 1 to 10, with 10 being the highest rating:

Circle one

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health rating to be?
1 2 3 4 5 6 7 8 9 10

Do you think your dental health effects your overall health? ☐yes ☐no

How often do you have your teeth cleaned? ________

When was the last time you had an oral cancer exam?
____

Is the brightness of your teeth important to you? ☐ yes ☐ no

Do you smoke or use tobacco in any form? ☐ yes ☐ no

How many soft drinks or sweet drinks do you have daily? ________

If you could change anything about your teeth – Would you make them?

- Whiter ☐ yes ☐ no
- Straighter ☐ yes ☐ no
- Close spaces ☐ yes ☐ no
- Replace black fillings with tooth colored ones ☐ yes ☐ no
- Repair chipped teeth ☐ yes ☐ no
- Replace missing teeth ☐ yes ☐ no
- Replace old crowns or caps that don't match ☐ yes ☐ no
- Have less gum showing ☐ yes ☐ no
- Be able to chew better ☐ yes ☐ no

Do you prefer to save your teeth? ☐ yes ☐ no

Have you had any teeth removed? ☐ yes ☐ no

Has a dentist or hygienist ever made you feel uncomfortable about your teeth or home care? ☐ yes ☐ no

What can we do to avoid this?
____
____

Date of your last cleaning: ________________

If there were a way to whiten your teeth for a reasonable investment, would you be interested? ☐ yes ☐ no

What is the most important thing to you about your future smile and dental health? ________________

What is the most important thing to you about your dental visit today? ________________

Dr. John M. Fox, D.D.S
201 South High Street
Sweetwater, TN 37874

FINANCIAL, APPOINTMENT, AND CONSENT FOR TREATMENT AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment at the time of your treatment is considered a part of your commitment to our office.

In order for us to provide the best experience, and to help you fit the care you want into your budget, we offer the following options regarding payment: Check, Debit Card, and Credit Card. **ALL** financing is handled through Care Credit (an application and credit check is required for this option). **Please understand that patient portion is due at the time of service regardless of insurance.**

REGARDING INSURANCE

If you have dental insurance, we will try to help you maximize your benefits. We can obtain information on your insurance to advise you what is estimated to be paid by the ins. company however it is your responsibility to know what your insurance will and will not cover. Any amount not covered by your insurance company is your responsibility to pay. We request that you pay your estimated portion plus the deductible on the day you receive treatment. We will allow up to 30 days for payment from your insurance carrier. After 60 days, we must ask that you intervene; at that time we will ask that you pay your balance and we will forward any insurance credits to you.

REGARDING APPOINTMENTS

It is your responsibility to provide us with a working telephone number to allow us to communicate important information, and to provide telephone reminders of scheduled appointments. Having a valid telephone number is truly important; please help us to maintain your records.

Effective October 30, 2013, each missed appointment will be flagged and you will receive a notice that you have missed your appointment. Accounts that accumulate three missed appointments may be dismissed from the practice. Any cancellation not made at least **48 hours before** the scheduled appointment is considered a missed appointment and subject to the terms above. If you arrive 15 minutes late for your scheduled appointment, without prior notification to our office, your appointment will be considered a "missed appointment" and you will have to be rescheduled for another day. Please remember that communicating with our office is critical for us to provide you with quality dental care. We understand that certain circumstances occur that do not allow you to keep your scheduled appointment, if this is the case, please call and discuss this with the office staff as soon as possible. Our schedule fills up quickly, and this will allow other patients to fill those slots.

We realize that there are times that you may arrive for a scheduled appointment time and are not able to be seen promptly at your appointed time. Please know that we go out of our way to make certain that this does not happen, however due to patient emergencies or other unexpected incidents, our schedule may occasionally fall behind. If this is the case, we will make every attempt to let you know the status of our schedule.

CONSENT FOR TREATMENT

The undersigned hereby authorizes Dr. John M. Fox, D.D.S. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information I have provided for this cart is true and correct to the best of my knowledge.

FINANCE CHARGES

I understand that any unpaid balance after 90 days will be charged a yearly finance charge of 18%, which is equal to 1.5% of my outstanding balance per month.

Should my account reach collection status (90 days) and I make no effort to pay off my balance, my account will be assigned to a collection attorney or agency. If my account is assigned to a collection agency, I will pay ALL costs of collection, including court costs and attorney's fees incurred by this office.

Thank you for taking the time to read and understand our financial and appointment agreement. Our practice is committed to providing the best care for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Patient/ Responsible Party Signature: ______________________________ Date: ___________________

Financial Coordinator: ____ Date: ___________________

Dr. John M. Fox

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

Updated 5/18/2015

I acknowledge that I understand the **HIPAA Notice of Privacy Practices;** I also acknowledge that I have the right to request a copy of the Dental Practice's **HIPAA Notice of Privacy Practices**. (Make request known to Front Office Coordinator and she will provide a copy for you.)

____
Patient Name (Please Print)

______________________________ ______________________________
Patient Signature Date

OR

____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: ____________________________

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:____

______________________________ ______________________________
Staff Member Signature Date