Patient Information

Name: _____
(First) (Middle) (Last) (Preferred Name)

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Work: _____ Home: _____

E-Mail: _____ May we contact you by e-mail or text? ___

Birthday: _____ Social Security #: _____

Emergency Contact: _____ Phone #: _____

Marital Status: _____ Employment Status: _____

Employer's Name: _____ Phone #: _____

Who may we thank for referring you? _____

Responsible Party for Insurance

Name: _____
(First) (Middle) (Last)

Birthday: _____ Social Security #: _____

Insurance Information

Primary Insurance Company: _____ Policy Holder: _____

Social Security # or Member ID: _____ Group #: _____

Employer: _____

Secondary Insurance Company: _____ Policy Holder: _____

Social Security # or Member ID: _____ Group #: _____

Employer: _____

Assignment and Release

I hereby assign my insurance benefits to be paid directly to Dr. Sam Carroll, D.M.D. I understand that I am financially responsible for any non-covered services. I also authorize Dr. Sam Carroll, D.M.D. to release any information required to process any and all of my dental claims.

Signed: _____ Date: _____

Sam A. Carroll, D.M.D.

Eaglesoft Medical History

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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	

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 use controlled substances?	○ Yes ○ No	If yes	

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

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 ○ 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 patient'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:_____

EFFECTIVE JANUARY 1, 2017

APPOINTMENT POLICY:

1. Patients are seen by appointment. Emergencies and walk-ins will be seen as time permits.
2. Our office uses advanced technology to confirm your dental appointment. We will send you text reminders, email reminders, and if need be, we will personally call you to confirm your upcoming appointment. We will exhaust every option to remind you of your appointment, and there is no reason why a patient would be unable to contact us through any one of these options in order to modify their appointment.
3. Patients failing to cancel or reschedule an appointment without a **72 HOUR NOTICE** will be subject to a **$75.00 FAILED APPOINTMENT FEE**.
4. We make every effort to see you at your scheduled time, and we appreciate when you are on time. If you are late for your appointment, we may need to reschedule you. You may also be subject to our **$75.00 FAILED APPOINTMENT FEE.**
5. **If you continue to be late, or build a history of failed or short notice canceled appointments, you may be dismissed from this practice and asked to seek your dental care elsewhere**.

FINANCIAL POLICY:

1. Payment is required **in full** at time of service. We accept cash, personal checks (**there is a $25 returned check fee**), Visa, Mastercard, Discover, American Express, and Care Credit.
2. If in the unusual circumstance that your account carries a balance, you will receive a monthly statement which may also include outstanding insurance claims. Interest will be charged on all accounts over 30 days old at the rate of 5% per month (60% per year).
3. Should the account become over 60 days overdue it will be referred to a collection agency. The undersigned agrees to pay the additional 40% collection fees, plus any costs and interest charged by the collection agency. In addition, should the account be referred to an attorney for collection, the undersigned agrees to pay reasonable attorney's fees, costs, and interest charged as a result of said referral. This collection agency reports to all three major credit bureaus. Your credit report will be negatively affected if you elect to disregard our attempt to collect your balance in full.
4. Our fees, when quoted for treatment, will be honored for 3 months. Beyond that, fees may be adjusted to reflect any cost increases.

INSURANCE POLICY: WE ARE NOT IN NETWORK WITH YOUR INSURANCE

1. As a courtesy to you, we will take assignment of benefits from you on some insurances and submit a claim to your insurance for you. You will have **estimated co-payments due at time of service (no exceptions)**. We attempt to gather accurate estimated payments from your insurance company, however we are out of network, which means we are not contracted with your insurance company, and do not know what they will pay until we submit a claim on your behalf.
2. All other patients with insurance will be asked for payment in full at the time of treatment. **We will provide you with an insurance claim for you to submit to your insurance for your reimbursement. We are not contracted with any insurance company.**
3. When a claim has been submitted, we will wait only 30 days for payment from your insurance.
4. Insurance claims are paid according to your dental benefits that were negotiated between your employer and the insurance company.
5. **YOU ARE RESPONSIBLE FOR YOUR DENTAL BILL REGARDLESS OF WHAT YOUR INSUANCE DOES OR DOES NOT PAY.**

The undersigned has read and understands the above stated policies, agrees to abide by them, and accepts financial responsibility for themselves and their dependents for any dental fees incurred at this practice. I understand that the dental office of 32nd Street Dental Care is out of network with my insurance company.

32nd St. Dental Care utilizes Facebook, Twitter, Instagram, LinkedIn, YouTube, Google+ and other social media platforms for the free exchange of information, customer service, as well as marketing. At times we will take pictures of our various patients during procedures or with the staff and potentially post them to our various social media outlets that we use, as well as to our website. We will not post a picture of you or your child without your consent.

SIGNATURE _____ **DATE** _____

PATIENT'S NAME _____

RESPONSIBLE PARTY _____