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.

Question	Answer	
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?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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:___________

232 Pond St. 2nd Floor, Natick, MA - 01760
Phone: (508) 318-6333 - Fax: (508) 318-6338

HOW DID YOU HEAR ABOUT US?

Patient Name: ______________________ Date: ___/___/_____

Please put a check mark next to all that apply:

- o Insurance Company: ____
- o Family/ Friend Referral: ____________________________________
- o Google Search/ Internet Search
- o Elite Dental of Natick Website
- o Elite Dental of Natick Facebook
- o Other (please specify): _____________________________________

232 Pond Street Suite 5
Natick, MA 01760
508-318-6333
info@elitedentalofnatick.com

elite dental
of Natick

232 Pond St. 2nd Floor, Natick, MA - 01760
Phone: (508) 318-6333 - Fax: (508) 318-6338

Consent for Treatment

A. I authorize the doctor and his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
B. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
C. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.

*Initials*________________

Assignment and release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all service not covered by my insurance. I authorize release of any medical care information requested by my insurance carrier. This agreement becomes effective the date the patient begins their first visit with Elite Dental of Natick.

*Initials*________________

Patient Responsibility and Financial Policy Agreement

The goal of Elite Dental of Natick is to provide exceptional customer service and excellent dental care with both a professional and personal touch. We want to make certain that our financial policies are clear and understood by you. If you have insurance, we will make a good faith estimate of your benefits. We will file the appropriate claim forms with your insurance company. We will also assist you in understanding your dental plan benefits. By signing this form, you understand your responsibility may alter depending on whether a third party (insurance) pays for all, part or none of the charges. Although we will make every effort to help you obtain your benefits, we cannot guarantee payment from your insurance. If the balance on your account is not paid within 90 days of your statement, the account will be closed and will be forwarded to a third party collection agency. If this becomes necessary additional fees may be added to cover handling charges. **All payments are due at the time treatment is rendered.**
I acknowledge my responsibility for payment of services rendered by Elite Dental of Natick in accordance with Elite Dental of Natick fees and terms.

*Initials*________________

Cancellation Policy

Here at Elite Dental of Natick we understand that interruptions to our schedules can and will occur. We are aware that from time to time people will encounter circumstances beyond their control. We do our best to accommodate each patient and their situation, however, our time is reserved for each patient and their specific oral needs and as such should be understood that our cancellation policy is established to benefit the patient and the practice. **Elite Dental of Natick is open from 9:00-6:00 Monday through Thursday and 8:00-2:00 every 1st and 3rd Saturday and 2nd and 4th Friday of the month.** Late cancellations, failed appointments, and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule we request **48 business hours notice for cancellations or rescheduling appointments. Canceling through voice mail or solution reach (text/email) is not an acceptable form of cancellation.** If a cancellation needs to be made, you must talk to a receptionist prior to 48 business hours. For appointments that exceed an hour or a consultation with a specialist, we require a $100 deposit that will be applied to services rendered on the day of the appointment. Specialist appointments need to be cancelled 1 week prior to the appointment. **In the instance of a late cancellation or a failed appointment Elite Dental of Natick reserves the right to charge a $65.00 fee for regular appointments and a $100.00 fee for lengthy appointments or specialist appointments.**

*Initials*________________

Records/ X-Rays

Elite Dental of Natick understands that you have the right to request copies of you dental records/x-rays. **We can provide your notes and x-rays with a fee of $25.00**; however, because we are licensed by the Massachusetts Board of Radiology to take X-rays, we are required by law to keep all original copies of your dental records.

*Initials*________________

elite dental
of Natick

232 Pond St. 2nd Floor, Natick, MA - 01760
Phone: (508) 318-6333 - Fax: (508) 318-6338

Acknowledgement of Receipt of Statement of Privacy Practices/Cancellation Policy and Financial Policy

I acknowledge that I have received a copy of the Statement of Privacy Practices and Cancellation policy for the office of Elite Dental of Natick. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Elite Dental of Natick reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Elite Dental of Natick. We may decline treatment if you revoke this consent.

Patient Name: ______________________________ Date ___/___/_____

Patient/Guardian Signature: ______________________ Date ___/___/_____

Witness Signature: ___________________________ Date ___/___/_____

Health Insurance Portability and Accountability ACT

The HIPAA Privacy Rule creates national standards to protect individual's medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patient's privacy rights.
- And it strikes a balance when public responsibility supports disclosure of some forms of data-for example, to protect public health.
- For patients-it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.
- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections
- It empowers individuals to control certain uses and disclosures of their health information.
- Acknowledgement of receipt of Notice of Privacy Practice. You may refuse to sign this acknowledgment.

I, ______________________, have received and read a copy of Elite Dental of Natick Notice of Privacy Practice, and understand my right pertaining to my personal healthcare and insurance information.

____
Patient/Guardian Signature Date _____/_____/______

____
Witness Signature Date _____/_____/______