Patient Information (confidential) Date_____

Name_____ Home Phone_____
Address_____ Cell Phone _____
_____ Work Phone _____
City _____Zip code_____
Email_____

Married [ ] Single [ ] Divorced [ ] Minor [ ]

Date of Birth_____
Social Security #_____
Drivers License # _____
Person to contact for emergencies and phone _____
Whom may we thank for telling you about us? _____

Insured Information

Subscriber Name_____ Social Security #_____
Birthdate of Insured_____Relationship to pt._____
Employer_____Date employed_____
Work address_____
_____
City_____Zip code _____
Insurance Company_____Group number_____
Ins. Co. Address _____
_____
City _____ Zip code _____
Please provide information for any additional dental coverage.

Responsible Party Information
Name of person responsible for this account_____
(If responsible party is NOT the patient, please fill out this section.)
Address_____Relationship to patient_____
_____Home phone_____
City _____Cell phone _____
Social Security #_____ Work phone _____

Continued on next page...

friedman
FAMILY & COSMETIC DENTISTRY

Friedman Family Dentistry, P.C.

Eaglesoft Medical History

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

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?

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 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:_____

Dental History

Please check all that apply

[ ] Currently experiencing dentally related pain
[ ] Gums bleed when brushing
[ ] Grind teeth
[ ] Sores or tissue problems in the mouth
[ ] Sensitive teeth
[ ] Have experienced difficult oral surgery
[ ] Have had braces or orthodontic treatment
[ ] Have had trauma/injury to mouth
[ ] Bleeding issues after surgery/dental work

When was your last dental visit and for what reason? _____

_____

Who provided this care?_____

Are there any dental concerns, cosmetic suggestions, or needs you would like to discuss? _____

Authorization and release

I certify that I have read and fully understand the above information to the best of my knowledge. I understand that providing false or incorrect information may be dangerous to my health. I have answered the above questions accurately. I authorize Friedman Family Dentistry to release any or all information including the diagnosis and records of any examination or treatment rendered to me or the person I am responsible for during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Friedman Family Dentistry insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the estimate and actual bill for services rendered. I agree to be held financially responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due and expected at the time service is rendered unless financial arrangements have been made in advance. I further agree to be responsible for any interest charges that can be added at the current legal rate, all collection fees, court costs, and reasonable attorney fees if this account is turned over to a collection agency or attorney.

Signature_____Date_____

Appointment and Attendance Policy

In order for us to provide the best possible dental care we require that you make all scheduled appointment times or cancel 24 hours in advance. A $50.00 fee may be assessed for missed appointments. Appointments cancelled within 24 hours of the scheduled time will be considered a missed appointment. By signing below, you acknowledge that you have read and understand this policy. Feel free to ask any questions or express concerns pertaining to this policy.

Signature_____Date_____

Continued on next page...

Local Anesthesia Consent

In order for us to make many of our procedures comfortable we use local anesthesia. However, there are risks involved with the administration and dental procedures. This form is designed to make you aware of the risks involved with local anesthesia. These risks include, but are not limited to:

--Dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, and allergic reactions. Any or all of these may require additional medical management or hospitalization.

--Restricted mouth opening during recovery, sometimes related to muscle soreness and swelling at the site of the injection.

--Prolonged numbness that, in some instances, may result in injury from biting or chewing an area such as the lip, cheek, or tongue.

--Injury to nerves that can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gums, or tongue. This may persist for several days, weeks, or in some very rare instances, permanently.

--Local anesthesia is administered with very small needles, which, in very rare instances, may break or become lodged in the tissue.

Please ask Dr. Friedman if you have any questions or concerns regarding local anesthesia or this consent form before you sign below and before any future treatment.

I acknowledge that I have read this document fully and understand that there are risks associated with local anesthesia.

Signature_____Date_____

FRIEDMAN FAMILY DENTISTRY FINANCIAL POLICY

Thank you for choosing us as your dental care provider! We are committed to providing you with the best possible care and cutting edge technology. The following is a statement of our financial policy, which we require you to read, sign, and date. This agreement will remain in effect for all services rendered during your time at our practice.

We accept cash, debit cards, checks, AMEX, Visa, Mastercard, and Discover. We also offer financing options through Care Credit.

Insurance

We file claims with your insurance company as a **courtesy**. **YOU** are responsible for payment of all services regardless of what the insurance company pays. Some of our services may not be a part of your specific benefit plan, or considered usual and customary by your insurance company. We recommend the best possible care for your dental health, NOT your insurance company's bottom line. **We will be more than happy to submit a preauthorization to your insurance company for your treatment before services are provided if you would like. We will NOT be responsible for differences between our estimates and payment from your insurance company for services. If you are concerned, PLEASE request that we submit a preauthorization.**

Usual and Customary Rates

Our practice is committed to providing the best treatment, with well trained staff, cutting edge equipment, and the highest level of customer service. We charge what is usual and customary for our area and level of care. Your insurance company's arbitrary determination of usual and customary rates may be more or less than our fees and you will be responsible for any difference. *In* and *out* of network questions can be answered by our front office staff.

Minor Patients

An adult should accompany a minor (less than age 18) for their appointment and will be responsible for any payment at the time of service. For unaccompanied minors, nonemergency treatment will be denied unless prior arrangements have been made and consent obtained from the guardian.

Emergency Walk-Ins

If a walk-in or emergency patient requires treatment, payment in full at the time of service may be required, regardless of insurance coverage. After verifying eligibility, the insurance company may be instructed to pay benefits directly to you.

Missed Appointments

A **$50** fee may be charged for missed appointments unless cancelled 24 hours in advance. If you are 15 minutes late, you may be asked to reschedule your appointment. A deposit may be required to schedule appointments exceeding 2 hours.

Self Pay Balances

These balances must be paid in full prior to your next visit. Balances of 60 days will be assessed a $20 billing charge. At 90 days there will be another $20 billing fee and your account may be turned over to a collection agency or attorney and you will be responsible for all collection fees, court costs, and attorney fees. We will do our best to contact you, but it is ultimately your responsibility to take care of any balance.

I have read, understand, and agree to this Financial Policy. Date_____

Printed Name_____Signature_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Friedman Family Dentistry
4011 Westfield Road
Westfield, IN 46062

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 multiple healthcare providers who may be in 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 received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of *Notices and Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient_____

Signature_____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date_____ Initials_____ Reason_____

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION "PHI"

This form will allow us to leave a message on voicemail or with individuals involved in your dental care.

PATIENT INFORMATION

Name of Patient_____

Phone number_____ Other number_____

Date of Birth_____

I (the undersigned) hereby consent to Friedman Family & Cosmetic Dentistry, leaving a voicemail message at the number(s) indicated above and/or discussing with the individuals(s) listed below information related to my PHI. These communications may include, but are not limited to, appointment reminders, insurance, treatment plans and financial information.

With my consent, Friedman Family & Cosmetic Dentistry may discuss PHI with the following individuals:

Name_____ Date of Birth_____
Relationship_____

Name_____ Date of Birth_____
Relationship_____

Name_____ Date of Birth_____
Relationship_____

I understand I have the right to revoke this consent at any time in writing, but that revoking authorization will not affect disclosures made or actions taken before the revocation is received. This consent is valid *for one year* from the date of execution.

I further understand that this consent does not permit the release of my actual medical records to the individual(s) listed above. Such release will only be made if I sign a separate valid authorization.

_____

Signature of Patient, Guardian, Parent, or Health Care Representative Date