TIME 10:21 AM

DATE 3/20/2018

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

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

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 10:22 AM | Sandhills Pediatric _Family Dentistry | Date 3/20/2018

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

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:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

STREET CITY STATE ZIP

Telephone: _____ Email: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Our Management Staff
(T) 919.499.9950 (F) 919.499.9940 Email: sandhillsdental@gmail.com
55 Amarillo Lane
Sanford, NC 27332

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION C: PERMISSION TO DISCLOSE INFORMATION

Do you give permission to disclose your health information, treatment, appointment, or payment to a family member (s), friend(s), or other person(s)? If so, please list them below.

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

SECTION D: PHOTOGRAPHIC RELEASE AND CONSENT

I, ______________________________, hereby authorize and consent to **Sandhills Pediatric and Family Dentistry** and its representatives the irrevocable and unrestricted right to reproduce, publish, print, use and distribute digital photographs and/or diagnostic x-rays of me, either in an official medical publication or in lectures for educational purposes. I further grant permission for my photos to be used on the Sandhills Pediatric and Family Denistry website, social media sites, or any other lawful purpose for advertising. I release Sandhills Pediatric and Family Dentistry and its employees and legal representatives from any and all claims, actions and liability relating to its use of said photographs.

The following exclusions may apply:

____

Signature: ______________________________ Date: ______________

MINORS ONLY:

If signature above is by a person under the age of 21, parent or guardian should sign below:

I ______________________ the parent or guardian, hereby consent to the foregoing.

Signature: ______________________________ Date: ______________

SANDHILLS PEDIATRIC & FAMILY DENTISTRY FINANCIAL RESPONSIBILITY

Payment is due at the time of service. We accept cash, debit cards, VIS, MASTERCARD, DISCOVER, CareCredit, and CitiHealth as a means of payment. As a courtesy, if you have dental insurance, we will file it for you. We encourage you to become familiar with the limitation of your dental plan (i.e., coverage, deductibles, frequencies, of procedures and copayments), as we will collect your cost share the day of service. On average, insurance claims are paid within 30-45 days. If your insurance claim is not paid within that time, you will receive a bill for payment. Upon receipt of payment from your insurance, we will kindly remit the credit balance to you. Your account will be assessed additional fees and collection charges of 1.5% if not paid within 30 days.

To avoid broken appointment and cancellation fees, we request a 24-hour courtesy call to cancel your reservation with us. A 48-hour courtesy call is requested for Saturday and appointments requiring an extended amount of time (i.e., root canal therapy; IV Sedation; oral sedation; oral surgery). You will be advised of the proper cancellation policy when you schedule your appointment.

SANDHILLS PEDIATRIC & FAMILY DENTISTRY AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and accurate. It is my responsibility to inform Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC of any changes in my personal information (Ie., telephone number, address, insurance carrier, and/or health.)
I understand that I am financially responsible for all charges, whether paid by insurance or not, at the time services are rendered. I authourize the use of my signature and authorize this office to submit claims, and assign benefits on my behalf to _____Insurance Company. Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC may use my health care information and may disclose information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date:_____