Time 11:12 AM | Dr. Ben Dansie | Date 11/30/2016

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

Do you use controlled substances?	Yes No	If yes
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	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:_____

DANSIE DENTAL

Insurance & Financial Policy

At Dansie Dental we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know about our office policies:

- **Dansie Dental requires payment in full for your portion at the time of service.** We accept MasterCard, Visa, American Express, Discover, cash, and checks. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12, 18, or 24 month "same as cash" designed to meet your treatment plan needs on approved credit. We do offer **10%** off, if your portion is paid in full with **"CASH", 5%** with check or Credit Card. **Dansie Dental charges $5.00 statement fee every month. After 90 days you will also be charged 10% interest each month.**
- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hour notice to avoid a $25 cancellation fee.** However if you are more than **15 min late** your appt will need to be rescheduled and charged the **$25 fee.**
- In the event of an emergency after regular business hours a **$50 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$100 after hour's emergency fee.**
- We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service.) This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY an Estimate.** If you would like to know you insurance benefits, we will be happy to file a "pre-treatment" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.
- We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Dansie Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

I agree with the above conditions.

Print

Name:_____ **Date:**_____

Patient/Parent Signature:

_____

DANSIE DENTAL
HIPPA
Consent Form

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practices Notice of Privacy Practices (for more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date_____

(Patient, parent, or legal guardian)

If signed by patient representative, state relationship to patient

DANSIE DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below. Read and sign the section at the bottom of the form.

- **WORK TO BE DONE**
  I understand that I am having the following work done: fillings___Bridges___Crowns___ Extractions___General Anesthesia___Exam, X-Rays & cleaning___
- **DRUGS AND MEDICATIONS**
  I understand that antibiotics and analgesics and other medications can cause allergic reaction causing redness and swelling of the tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction)
- **CHANGES IN TREATMENT PLAN**
- I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restoration procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
- **REMOVAL OF TEETH**
  Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc) and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in the paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. The cost of which is my responsibility.
- **CROWNS BRIDGES AND CAPS**
  I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing a temporary crown, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.
- **DENTURES COMPLETE OR PARTIAL**
  I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problem of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
- **ENDODONTIC TREATMENT (ROOT CANAL)**
  I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedure may be necessary following root canal treatment (apicoectomy)
- **PERIODONTAL LOSS (TISSUE & BONE)**
  I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and or extractions. I understand that undertaking and dental procedures may have a future adverse effect on my periodontal condition. I understand that dentistry is not an exact science and that, therefore; reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the denial treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I CONSENT TO THE PROPOSED TREATMENT.

SIGNATURE OF PATIENT:_____DATE_____
SIGANATURE OF GUARDIAN (if patient is a minor)_____DATE_____