Bellaire Periodontics

PATIENT INFORMATION

Date: ☐New Patient ☐Update

Patient:

Last First MI Preferred Title

☐Male ☐Female ☐Child* ☐Student** ☐Single ☐Married ☐Divorced ☐Widowed

*If Child, provide parent/guardian name(s) below:

Parent/Guardian Name(s)

**If Student, please complete: ☐Full-time ☐Part-Time

School/Location

Patient Date of Birth: Patient SSN:

Address:

Address Line 1

Address Line 2

City ST ZIP Code

E-Mail:

Home:
Cell:
Other:
Pager:
Fax:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

Name Relationship Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

Address Line 1

Address Line 2

City ST ZIP Code

E-Mail:

Work:
Direct:
Other:
Pager:
Fax:

INSURANCE INFORMATION

Subscriber:

Last First MI Preferred Title

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Primary Insurance Carrier:

Group/Policy No.: ID No.:

Address:

City ST ZIP Code

Tel:
Toll-free:
Fax:

Secondary Insurance Carrier:

Group/Policy No.: ID No.:

Address:

City ST ZIP Code

Tel:
Toll-free:
Fax:

Time 9:48 AM | Dr. Sharon Minott-Warren | Date 10/2/2020

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		
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:_____

Written Financial Policy

Thank you for choosing Bellaire Periodontics. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard or American Express

  We offer a 5% accounting courtesy to patients who pay for their treatment with cash or check at consultation appointment for treatment plans of $500 or more. **(NON –INSURED PATIENTS ONLY)**

- Convenient Monthly Payment Options[1] from Care Credit Healthcare Credit Card & The Lending Club
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Bellaire Periodontics requires payment at the beginning of your treatment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

For patients with medical insurance, we will work with your carrier and directly bill them. However, if they will consider your services as a covered benefit, we collect up front and reimburse you once they have paid.

Bellaire Periodontics charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Signature: _____ Date: _____

Regarding Insurance

We will accept assignment of insurance benefits. This means that your insurance carrier will pay us instead of you. However your insurance policy is a contract between you and your insurance carrier. We have no control over their decisions and the amount they decide to pay.

Before filing a claim on your behalf, we will attempt to verify your coverage and calculate your deductible and co-payments as accurately as possible. All deductibles and co-payments are due at the time of service.

You should be aware that your insurance carrier will not guarantee payment over the telephone. We will not know the exact amount they will pay until they respond to the claim. Regardless of what your insurance decides to pay, you remain fully responsible for payment of your bill. Once payment is received on your claim, we will send you a bill for any balance remaining on your account.

If we do not receive payment from your insurance carrier within **90 days**, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Signature: _____ Date: _____

Cancellation Policy

Here at **Bellaire Periodontics** we strive to render excellent dental care to all our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to accommodate all our patients. When an appointment is scheduled, that special time has been reserved for you and when it is missed, that time cannot be made available to another patient.

For Hygiene appointments we request a 48 hour notice for canceling or rescheduling appointments. If we do not receive a 48 hour notice, you will be charged a $75 cancellation fee.

For Surgery visits we request one week notice for canceling or rescheduling appointments. If we do not receive a one week notice you will be charged a $125 cancellation fee.

We value all of our patients and we sincerely appreciate your cooperation.

Patient Signature: _____

Date: _____

BELLAIRE PERIODONTICS

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("Authorization")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgment.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement
___ A communication barrier prevented us from obtaining acknowledgment.
___ The individual was unwilling to sign.
___ Other: _____

_____ _____
Staff Member Signature Date

MEDIA RELEASE FORM

I, _____, grant permission to _____, hereinafter known as the "Media" to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

❏ Videos ❏ Email Blasts ❏ Recruiting Brochures ❏ Newsletters ❏ Magazines
❏ General Publications ❏ Website and/or Affiliates ❏ Other: _____

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

_____ - I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: _____ Date: _____

Name (please print): _____

Address: _____

Signature of parent or legal guardian: _____
(if under 20 years of age)