Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address: _____

City, State, Zip_____

Home phone _____ Cell phone _____E-mail_____

May we text you to confirm/schedule appts? Y N May we e-mail you to confirm/schedule appts. Y N

Patient Marital Status: Single Married Widowed Divorced Sex: Female Male

Patient Social Security Number _____ Date of Birth_____

Emergency Contact _____ Phone _____

Preferred Pharmacy_____ Phone # _____

How did you hear about us? Radio Post Card Internet Referral _____ Other _____

Do you have Dental Insurance? Yes, No Subscriber Name (who carries insurance) _____

Subscriber ID or SSN _____ Subscriber Date of Birth _____

Relationship to Subscriber: Self Spouse Child Other

Employer Name _____ Insurance Company _____

Insurance Group # _____ Insurance Phone # _____

Please present your Photo ID and Insurance Card at your appointment to be photocopied.

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, 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:_____

Financial Agreement

Thank you for choosing our dental practice. Dental treatment is an excellent investment in an individual's overall well-being. We are committed to providing you with the best possible dental care and are pleased to discuss any of our professional fees at any time.

Payment is expected at the time of service. Payments can be made by cash, check or credit card. We also offer Care Credit Financing for qualified applicants with up to 6 months of free financing. An application may be filled out in our office, or you can apply online at www.carecredit.com.

Insurance - For our patients with dental insurance, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the **insurance company** and the **patient**. As such, **we cannot make a guarantee of estimated coverage or payment**. However, please know that we will do everything possible to see that you receive the full benefits of your policy. If the patient's insurance fails to make full payment after 60 days, the patient is responsible for paying the outstanding balance on his/her account.

Flex Plan / Spending Accounts - Payment in full is expected at the time your service is rendered. We will be happy to give you a copy of your receipt which will allow you to submit the amount to your Flex Plan/ Spending Account for reimbursement directly to you.

Short Notice Cancellations - If there has not been a reasonable amount of time given prior to your cancellation, a fee may be charged to your account. **We reserve the right to charge and collect fees for appointments that are cancelled or broken without 48-hour notice.** Appointments are reserved specifically for you. If cancelled or failed, the time is taken away from other patients who are waiting to be placed on our schedule. **A fee of $100 for the first and $125 for the second failed appointment will be charged to your account.**

Returned Check Fee - $50 will be added to your account balance if a check is returned to us as Non-Sufficient Funds (NSF).

I accept full financial responsibility for all treatment performed by Dr. Kumar. I understand payment is expected at the time services are rendered. I understand that insurance coverage is a contractual arrangement between my insurance company and I ("the patient"). I understand that if my account becomes past due, I will be responsible for all fees, interest charges, late charges and all costs of collection including, but not limited to, attorney fees and court costs.

Signature of Patient, Parent or Guardian, or Responsible party

_____

Witness: _____ Date: _____

3RD ST. DENTIST REE
2301 E 3RD ST
Bloomington, IN, 47401

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of *HIPAA Notice of Privacy Practices* .

I understand that 3RD ST. Dentistree's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of 3RD ST. Dentistree's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about 3RD ST. Dentistree's *HIPAA Notice of Privacy Practices*, I may contact the Office Manager .

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that 3RD ST. Dentistree will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding 3RD ST. Dentistree's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask the Office Manager, noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative
	_____
	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

3RD ST. Dentistree made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its HIPAA Notice of Privacy Practices. Despite these efforts, 3RD ST. Dentistree was unable to obtain a signed Acknowledgement for the following reason(s):

o Refusal to sign Acknowledgement on _____, 20_____.

o Communication barriers prohibited us from obtaining a signed Acknowledgement.

o An emergency situation prohibited us from obtaining a signed Acknowledgement.

o Other (Describe):_____

Date Received	By	Patient ID

Photo Consent Form

I consent to Dr. Pooja Kumar and staff to take photo(s) / x-rays as part of my dental records. The photo(s) / x-rays taken at 3RD ST. Dentistree may be used for submitting dental insurance claims. They will assist the doctor and staff in identifying area(s) of concern and forward them to any specialist(s) (if needed). We will not share or use your photo(s) / x-rays for anything other than your chart without your permission.

Signature_____ Date_____

Information Release Form

3RD ST. Dentistree requires that our staff obtain authorization from the patient to release and/or leave a detailed message for the patient. This is secondary to the new HIPAA guidelines needed to guard against violation of patient confidentiality and to protect our staff.

By signing below, I consent to Dr. Pooja Kumar and staff to leave messages regarding my care and/or upcoming appointments on my home or personal cell phone.

Signature_____ Date _____