

PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Date ____ / ____ / ____
Patient's Full Name _____ Age _____ Birthdate ____ / ____ / ____
Address _____
City _____ State _____ Zip _____
Social Security No. _____ Home Phone No. _____

DENTAL INSURANCE

Primary Carrier Insurance Company _____ Date of Birth _____
 Group No. _____ Date Employed _____ Employee _____
 Secondary Carrier Insurance Co. _____ Emp. Social Security No. _____
 Group No. _____ Date Employed _____ Employee _____
 Emp. Social Security No. _____
 Date of Birth _____

ACCOUNT INFORMATION

Name of Person Financially Responsible For Account _____
 Address _____
 City _____ State _____ Zip _____
 Occupation _____ Employer _____
 Business Address _____ City _____
 Business Telephone _____ Ext. _____
 Marital Status (check) married _____ Single _____ Divorced _____ Widowed _____ Separated _____
 Spouse's Name _____ Spouses Social Security No. _____
 Spouse's Occupation _____ Spouse's Employer _____
 Business Address (Spouse) _____ City _____
 Business Telephone (Spouse) _____ Ext. _____
 Person To Contact For Emergency _____ Phone No. _____
 Address _____ City _____ State _____ Zip _____
 Referred to Us By _____

DENTAL HEALTH HISTORY

1. Chief complaint or reason for visit _____
2. Date of last dental visit _____
3. Are you experiencing discomfort from your mouth at this time? _____
Explain: _____
4. Have you had full mouth x-rays (18 x-rays) or a panorex within the last two years? _____
Name and address of dentist where x-rays were taken _____
5. Circle any of the following which you have had or have at present:

Periodontal (gum) treatment	Orthodontic (braces) treatment
Endodontic (root canal) treatment	Bleeding sore gums
Swelling or lumps in mouth	Difficulty opening or closing jaw
Clenching/grinding	Loose teeth
Tooth sensitivity to biting	Tooth sensitivity to cold
Tooth sensitivity to hot	Food impaction
6. Are you satisfied with the appearance of your teeth? _____
7. Does your drinking water contain fluoride? _____

Springcrest Dental Associates
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?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Other?	<input type="checkbox"/>	If yes	_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever had any serious illness not listed	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
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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: _____

Elizabeth J. Rutledge, DDS, PLC

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPM's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy 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.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

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

Patient Acknowledgement

I acknowledge that today I have received a copy of the Notice of Privacy Practices.

Patient Signature

Patient Name (please print)

Date: _____

Patient Consent

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature

Patient Name (please print)

Date: _____

Springcrest Dental Associates
Financial Policy

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive proper and optimal treatments needed to restore your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our office staff. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, Mastercard, American Express and Discover. For your convenience, we do offer financing through Care Credit. We will be happy to help you process your application and your insurance claim for your reimbursement as long as you bring the required information to each visit. Most insurance plans are payment assistance plans; they are not designed to cover the entire costs of treatment.

Our financial policy is as follows:

1. We bill most insurance plans as a courtesy to you. Your deductible and/or co-payment for our services is due in full at time of treatment.
2. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. Any disputes with your insurance company are your responsibility.
3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
5. If the insurance company does not pay after 90 days, we require you to pay the balance due with cash, check, or credit card.
6. Returned checks will be subject to additional fees.
7. All balances over 90 days will be reviewed and turned over to an agency for payment or will be sent to our Legal Counsel. You will be responsible for any additional charges incurred.
8. We reserve the right to charge a fee for broken appointments.

We understand that temporary financial issues may affect timely payment of your account. We encourage you to communicate any such problems so that we may assist you in the management of your account.

Patient Signature: _____ Date: _____