PATIENT INFORMATION

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Birth Date _____ Social Security # _____

Whom may we thank for referring you to our office? _____

Email _____ Date _____

RESPONSIBLE PARTY INFORMATION

Name _____ _____
Last First Middle Marital Status

Address _____
Street City State Zip

How long at this address ____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State

Social Security # _____ Driver's License # _____

Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle

Spouse's Employer _____ Occupation _____ No. Years Employed _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Address _____

Insurance Company Phone _____ Insured's DOB _____

City, State _____ Phone _____

ID # _____ Group No. _____ Local No. _____

Do you have secondary coverage? Yes □ No □ If Yes;

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative **not** living with you _____

Complete Address _____

Phone Number _____

Thomas J. Raia D.D.S. PC

Eaglesoft Medical History

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:_____

Patient Agreement Form

I hereby authorize the release of pertinent medical information to my insurance carrier. I am aware that dental insurance coverage varies and, while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, **I am ultimately responsible** for payment of all charges for services rendered by Crest Hill Family Dental for myself or my immediate family. If I have insurance, I understand that I will be responsible for any co-payments, deductibles or procedures that may not be considered "a covered procedure" by my insurance company.

Your dental insurance benefit program is a contract **between you, your employer and the insurance company.** We are not party to that contract. Insurance companies do not dictate the standard of care, but reimburse for a limited number of procedures. Not all dental services are a covered benefit. **It is not our responsibility to know your benefits, it is yours.** We contact your insurance company to get basic benefit information, so that we can give an **estimated** co-pay amount on your treatment plan. However, your insurance company will not guarantee exact amounts, therefore the co-payment amount we provide is **only an estimate**, not a guarantee. The only insurance company that we are contracted with as a preferred provider and are subject to their fee schedule, is Delta Dental. We do submit to all insurance companies that allow a member to choose the Dentist that they would like to see. Remaining amounts are subject to balance billing as per the insurance company guidelines.

I understand and agree that if I fail to keep any scheduled appointment, and do not give **at least** 48 hours notice, **I will be charged one half of my scheduled anticipated appointment charges.** I understand that I am solely responsible for this missed appointment fee and it **will not** be billed to my insurance company.

_____ _____

Patient name (parent or guardian if minor) Date

_____ _____

Signature Date

If you are here as a new patient a comprehensive dental examination, appropriate x-rays and a professional dental cleaning will be performed, if appropriate. At that time a comprehensive dental treatment plan will be completed and the associated procedures and fees will be discussed at that time.

Payment options are cash, Visa or MasterCard, Discover, American Express, check, or debit card. Payment plans are offered solely through Wells Fargo or CareCredit.

Wells Fargo is a payment option that our office offers to patients who have large or small amounts of treatment to accomplish. It involves an application process that can be done online at www.wellsfargo.com or in our office after completing a standard application. Once approved there are 6, 12 and in some cases 18 month interest free payment plans. Wells Fargo also offers extended payment options at 12.99% APR.

CareCredit is another payment option that our office offers. It also involves an application process that can be done online at www.carecredit.com , in our office after completing a standard application or by calling 1-800-365-8295 and utilizing the automated phone application process. Once approved there are 6 and 12 month interest free payment options. Extended payment plans are also available which are based on 14.90% APR. (Subject to change) Information on this option is always available at our office.

There is a 3.0% (36% APR) monthly late charge assessed on all balances after 60 days past due. Checks, which are declared non-sufficient funds, will be charged a $25.00 service fee. Also, the undersigned agrees to pay a collection fee of 50% of the total owed when sent to collection, **all** attorney fees and court costs incurred by the creditor.

I have read and understand the above paragraphs in their entirety and all information provided is correct.

_____ _____

Patient name (parent or guardian if minor) Date

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NOTICE OF PRIVATE PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient_____

Signature_____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

We kindly request that you provide your email address, so that we may confirm your appointment with Dr. Raia or Pamela our hygienist. Thank you for understanding our effort to enhance our communication with our patients.

We will also be providing brief newsletters and monthly cosmetic promotions including Lumineers, in office whitening or Snap-On specials. If you would prefer not to be contacted regarding our monthly emails, please check NO below.

Thank you for your understanding in our continuing effort to communicate with our patients in the most effective way possible.

Sincerely,

Thomas J. Raia, D.D.S.

_____

Patient Name

_____

Address

_____

Cell Phone

_____

Birth Date

_____

Email

NO_____ I prefer not to receive emails or special offers.

Missed Appointments

In today's ever demanding schedule that we all navigate, it is only natural that at times we may forget our dental appointment. In our offices best attempts to reschedule missed appointments we do expect the SECOND appointment to be maintained.

To reschedule a missed appointment, your co-payment must be paid if insurance is involved, for the appointment to be rescheduled. If no insurance is involved, your entire anticipated treatment cost must be paid for your appointment to be rescheduled.

If the SECOND appointment is missed your co-payment or payment in full will be forfeited to compensate for the previously missed appointments. Our intention is to provide the care that has been advised with your initial appointment and NOT to forfeit your payment toward treatment.

Our goal is to provide your dental care with the proper scheduling time necessary for that appointment. Maintaining dental appointments are important to achieve this goal. Thank you for your understanding and we look forward to helping provide your dental care.

_____

Signature Date