Patient Registration:

Today's Date_____

Last Name_____ First Name_____ MI_____

DOB_____ Age_____ Soc. Sec. #_____ Sex M or F

Mailing Address_____ City_____ State _____

Zip Code _____ Please Circle One: Single Married Separated Widow Divorced

Home # (___)_____ Cell # (___)_____ Email _____

Employer_____ Occupation_____ DL#_____

Emergency Contact_____ Relationship_____

Phone # (___)_____

Are you a full time student? Yes or No

If Patient is a Minor:

Name of Parent/Person Responsible for Account_____

Relationship to Patient_____ DOB_____ SS#_____

Address (if different than Patient)_____

Phone # (___)_____ Employer _____ _____

Dental Insurance Information (Primary)

Insured's Name_____

Insured's Employer_____

Insured's DOB_____

Ins. Co. Address_____

Insurance Phone #_____

Group #_____ ID#_____

Dental Insurance Information (Secondary)

Insured's Name_____

Insured's Employer_____

Insured's DOB_____

Ins. Co. Address_____

Insurance Phone #_____

Group #_____ ID# _____

How did you hear about us?_____

Time 7:32 AM | Eiler Family Dentistry | Date 6/24/2015

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		

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 use controlled substances? Yes No 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:_____

Dr. Robin Eiler

13240 Crystal Hill Rd.

North Little Rock, AR 72113

Financial Policy

Thank you for choosing our office as your healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards, debit cards and Care Credit.

Please let our office know if you would like information about the Care Credit financing option.

Insurance Policy

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card, debit card or Care Credit financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- Be aware that many insurances will DOWNGRADE composite (tooth colored) fillings and pay based on their allowed amount for silver fillings with little or no warning. This is a lesser amount paid by your insurance. If your policy does this, you will be billed the additional amount for each composite tooth filling.
- If we are not in network with your insurance, our standard office fees will apply for all services and you will be responsible for payment on the day of service.

Cancellation / No Show Policy

We ask that you give at least a 24 hour notice from the time of your appointment to cancel if you cannot make it. We make that appointment especially to attend to your oral health care needs. Our office needs time to fill your appointment time in the event you cannot come. Any patient who fails to give a notice or doesn't show will be subject to a $25.00 fee.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee may be added to any overdue balance.

_____ _____

Patient Signature (or Parent of Minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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