Eaglesoft Medical History(Copy)

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

Do you use controlled substances?	Yes No	If yes
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	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:_____

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James C. Vogler, DDS, PC

Financial & Appointment Policies

Financial Policy: Payment in full is required at the time of service. We accept cash, personal checks & all major credit cards. If you need financial assistance, we do participate with Care Credit & their website is www.carecredit.com to be approved. Our office offers 12 months interest free for anything over $200.00.

Dental Insurance: We would like to stress that our relationship is with you & not with your insurance carrier. We will bill your insurance for you & send any necessary letters, x-rays & pre-determinations. If we can verify your coverage & your insurance company will send payment **directly** to our office, we will bill your insurance & you will be required to pay your **ESTIMATED** difference & or deductible at the time of service. Fees incurred for dental treatment are your responsibility regardless of insurance reimbursement. Our office will require your Social Security Number **if** we are filing dental insurance as it is an extension of credit.

Unaccompanied Minors: NYS law requires parental consent for all services provided to a minor. A parent or guardian **MUST** accompany children under **18** years old to their **first** dental appointment.

Appointment Policy: A scheduled appointment is an agreement between the patient & the dental provider. **We** agree to reserve the time, staff & equipment to serve you. **We** ask that you be here on time to receive that service.

Broken Appointments: Please be considerate of other patients. **IF** you fail to show for an appointment or call to reschedule your appointment with **less** than **24 hours'** notice, you deny other patients the opportunity to use that appointment time. **A $25 fee may be assessed for appointments that are broken or cancelled with less than 24 hours' notice.**

We certainly understand when emergencies happen, however, patients who establish a pattern of **Broken appointments** or **late cancellations** will be dismissed from our practice to seek their care elsewhere.

I have read & understand the above policies & agree to abide by them.

Patient/Guardian Signature: _____ **Date:** _____

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(585) 335-2120

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DESIGN
James C. Vogler, DDS, PC

Release of Records / Request of Records

I, hereby authorize the release of my dental records and radiographs from the dental practice of: _____

_____

_____

Patient Name: _____

Patient D.O.B.:_____

Patient's Signature: _____Date: _____

****If possible, please email the records and radiographs to:**
asmilebydesign@frontier.com

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that 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 that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 below to obtain a current copy of the *Notice of Privacy 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 healthcare 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: _____

Signature: _____ DATE_____

Authorization to Release Information to Family Member /Other

I, _____, give permission to Dr. James Vogler

& his team members to discuss my health & dental situation /treatments with the following persons:

Name: _____

Contact Numbers:

Home: _____ **Cell:** _____

Name: _____

Contact Numbers:

Home: _____ **Cell:** _____

This authorization shall be in effect from this day forward & until

I advise Dr. James Vogler & his team members otherwise in writing.

Patient's Signature: _____ **Date:** _____

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