

**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 <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  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 & 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](http://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: \_\_\_\_\_

*Making our community beautiful, one smile at a time...*



## 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:**

**[info@asmilebydesign.com](mailto:info@asmilebydesign.com)**

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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/Minor Name: \_\_\_\_\_

Patient/Guardian 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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