To be seen in our office, it is mandatory that all forms are read and signed before being seen.

Name ____ Date of Birth________________ Sex: Male/Female

SS# __________________________ Driver's License #__________________ Nickname __________________________

Status: Married, Single, Divorced, Widowed, Minor

Address ____ City ______________ State ______ Zip ______________

Cell Phone ______________________ Home Phone ______________________ Work Phone ________________________

Email ____________________________________

Employer Name ________________________________ (If minor, name of school)

Employer Address ______________________________ City ______________ State ______ Zip __________

Emergency Contact _____________________ Phone ____________________________

Please circle how you heard about our practice?

Flyer in Mail | **Internet Search** | **Insurance Plan** | **Facebook/ Instagram** | **Exterior Sign** | **Friend/ Relative**

If you were referred by a current patient, whom may we thank? ____________________________

Other: ____________________

Responsible Party/Insurance Policy Holder

- Please check here if this is same as above

Name of Policy Holder _____________________________________ Relationship to Patient _______________

Address __________________________________ City ______________ State _____ Zip ____________

Date of Birth ___________SSN _________________ Phone # _____________ Email __________________________

Employer Name ______________________________

Employer Address ___________________________City _____________State_____ Zip ___________

Dental Insurance Company Name _______________________________ Group# _______________

Policy/Subscriber ID# __________________________

Insurance Address _____________________________ City ______________State ______ Zip _____________

I authorize release of any information required in the course of the examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

Responsible Party's Signature ____________________________________ **Date** __________________

Dental History

We want to make you smile!

Are your teeth sensitive to hot/cold?.............	Yes	No
Are your teeth sensitive to sweet/sour?.........	Yes	No
Have any sores in/around mouth?..............	Yes	No
Have you noticed any mouth odors?..............	Yes	No
Do you have loose teeth?..............................	Yes	No
Do you have pain in your teeth?....................	Yes	No
Difficulty opening/closing mouth?................	Yes	No
Difficulty chewing?..	Yes	No
Ever had periodontal treatment?............	Yes	No

Have you ever had braces?.....................	Yes	No
Difficult extractions in past?..................	Yes	No
Do you have frequent headaches?..........	Yes	No
Do your gums bleed when flossing?........	Yes	No
Have you ever had head/neck injury?.....	Yes	No
Do you wear dentures?............................	Yes	No

If yes, date of placement: ________________

Do you have dental anxiety?................. Yes No

If yes, would you be interested in sedation dentistry? Yes No

Do you want whiter teeth?	**Yes**	**No**	**(If yes, ask us how to get free whitening for life!)**
Do you want straighter teeth?	**Yes**	**No**	
Do you like your smile?	**Yes**	**No**	
Do you grind your teeth?	**Yes**	**No**	
Do you snore or have sleep apnea?	**Yes**	**No**	

What would you change about the appearance of your teeth? ____________________

How often do you brush your teeth? ____________________

Do you own an electric toothbrush? ____________________

Date of last dental exam? ____________________

Date of last cleaning visit? ____________________

How often do you floss? ____________________

Previous Dentist's Name ____________________ Address ____________________

If there is anything else about having dental treatment that you would like us to know or if you had an experience in the past that you would like to share with us, please describe:

____

____

____

Time 8:35 AM

Seamless Dentistry

Eaglesoft Medical History

Date 1/5/2023

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.

Question			
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 Financial Policy

50% Deposit to Schedule Treatment: Our office does have a policy that patients must pay 50% of their out-of-pocket patient portion to schedule any dental treatment. Unlike busy corporate office, we reserve time just for you and the doctors and a great way to hold your spot as there is normally a waiting list to get in sooner. The remaining amount will be due while you arrive to your dental appointment for a faster check out afterwards.

Flexible Payment Plans: Payment plans are for orthodontic treatment (braces) only. You can however make payments to your dental account here, like "lay-a-way", but you will not be able to start dental treatment until paid in full. If ortho payments are late, there is a $25 fee for every month it is late and next ortho trays will not be given until account is caught up financially.

Insurance: We accept and all PPO dental insurance. Please provide us with your dental card. As you can imagine, it is virtually impossible to know each patient's insurance coverage for there are thousands of different plans. We only verify if you have coverage and the basic breakdown of your benefits. You are responsible for knowing what services your insurance company does and does not cover and when services were last rendered to you. Please understand that this contract is between you and your insurance company and payment for services is your responsibility. Our insurance department will gladly file your claim up to two times. If at the end of 60 days, your insurance company had not paid, you will be responsible for the entire balance and you will have to contact your insurance company to find out why they didn't pay. Again. Dental insurance is just a form of payment for us. We are NOT the same company.

Office fees/Other: Outstanding balances will automatically send a text to pay to patients when claim has been posted. If account is not paid within 60 days, there is a $25 billing fee added every month. All accounts go to collections after 6 months and you will not be able to return to our dental office until paid in full. We are a small private owned practice and we have to have account balances paid to continue our provider relationship with our patients. If you present a check for insufficient funds, or place a stop payment on an issued check, you will be charged a $35 fee for processing. Insufficient fund will not be reprocessed, and you must pay by cash, credit card or money order.

Broken Appointment Policy: Please consider your scheduled appointments carefully. In order to allow the best possible care for our patients we reserve time on our schedule just for you. We require a 48 hour cancellation notice. Although we understand things come up, if we do not receive a 48 hour cancellation notice you may be charged with a broken appointment fee. We appreciate your promptness and your consideration in not changing your scheduled time.

I understand and agree to the financial policy of Seamless Dentistry. Regardless of what my insurance pays, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of my dental insurance benefits to be made directly to Seamless Dentistry.

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Patient/Responsible Party Date

Dental Insurance

In order for us to honor your dental insurance, please be sure to provide us with your dental insurance card. Please note that all professional services are rendered and charged to you, not your insurance company. We will file your primary insurance for you, however because most plans only cover a portion of the dental fee, you will be asked to pay the deductibles and co-payment amounts not covered at the time of service. Please understand that the contract is between you and your insurance company and payment for services is your responsibility. While we do try to help you maximize your benefits, our office will not enter into a dispute with your insurance company over your claim. Our insurance department will file your claim one time. If at the end of sixty (60) days, your insurance has not paid, you will be responsible for the entire balance regardless of benefit expectations. You may feel free to ask any team member of our office for clarification on services, billing, and insurance.

Usual & Customary Fees:
Our fees are what is usual and customary in our area, not what your insurance company feels are usual and customary. You are responsible for any fees that are above your insurance company's usual and customary fees unless we have a contract fee with your insurance company or are a participation preferred provider (PPO) for your insurance company.

Patient Agreement to above and the following:

- ✓ We only verify if you have coverage and the basic breakdown of your benefits. You are responsible for knowing what services your insurance company does and does not cover and when services were last rendered to you.
- ✓ If after 30 days you insurance company has not paid, it is your responsibility to call your insurance company to see why they have not paid your claim.
- ✓ You are responsible to pay all deductibles and co-payments at the time of your service. If you cannot pay in full you may set up financial arrangements prior to your service.
- ✓ Insurance companies do not guarantee us payments so any fees stated to you are **estimates only**.
- ✓ We must be able to verify that you have coverage with this insurance. If we cannot verify your insurance you will have to pay for your visit in full and we will provide you with the proper paperwork to file your claim.
- ✓ You are responsible for any monies that your insurance company does not cover, i.e. alternate benefits, oral cancer screening, denied claims due to missing tooth clause, frequency of services, age limitations, deductibles, plan limitation, etc.

We understand that it can be frustrating and confusing when it comes to your dental insurance. We want you to know that our team is committed to making your visit with us a positive one! The dental treatment in our office will never be based on what your dental insurance does or does not cover. Your overall health is our main priority.

I understand my insurance plan may not cover for all services. I will be responsible for any non-covered services. I agree to be fully responsible for a timely payment of the charges amount.

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Patient/Responsible Party Date

Authorization Use or Disclosure of Patient Photographic and/or Video Images

Here at the office of Seamless Dentistry we are a big fun loving family! We love to show the world that dentistry isn't anything scary. We do that by real testimonials, real pictures and those smiling faces on real patients just like you. However, we need your permission to do so, in writing. ☺

Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to disclosure and may no longer by protected by HIPAA privacy regulations.

Purpose:

The photographic/video images, and/or testimonial will be used for social media and/or advertising.

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

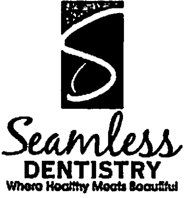
If desired, copy provided:

Please let our Seamless staff know if you would like a copy of this form.

Patient Signature: ______________________________________ Date: ____________________

If Patient is a Minor:

Parent/Legal Guardian Signature:___________________________ Date:______________________



Acknowledgement of Receipt
For Notice of Privacy Practices

Patient Name: ___________________________________

I have reviewed and understand the Notice of Privacy Practices for the above named practice.

____ ______________________
Patient/Responsible Party Date

For Office Use Only

We are unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because of the following:

- ☐ **An emergency existed and a signature was not possible at this time.**
- ☐ **The individual refused to sign.**
- ☐ **A copy was mailed with a receipt for a signature by return mail.**
- ☐ **Unable to communicate with the patient for the following reason:**

____

- ☐ **Other:** ____

Team Member: ____________________________________ **Date:** ______________________