SPRINGSDENTAL
CARING · COMFORTABLE · QUALITY · AFFORDABLE

PATIENT INFORMATION:

Name: _____

Address: _____

City, State, Zip: _____

Phone: Home (_____) _____ Work: (_____) _____ Cell: (_____) _____

E-mail: _____

Sex: O Male O Female **Marital Status:** O Married O Single O Divorced O Separated O Widowed

Birth Date: _____ Social Security # _____ Driver License # _____

Emergency Contact: Name _____ Phone (_____) _____

Preferred Pharmacy: _____ Location: _____

Preferred method of contacting you: (check one or more) Phone_____ Email _____ Text _____

IF PATIENT IS UNDER 18 YEARS OLD:

Responsible Party: _____ Phone (_____) _____ Relationship to Patient _____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY DENTAL INSURANCE:

Insurance Company Name: _____ Phone # (_____) _____

Insured's Name: _____ Birth Date: _____ ID#:_____

Insured's Employer: _____Group #: _____

Relationship to Patient: _____

SECONDARY DENTAL INSURANCE

Insurance Company Name: _____ Phone # (_____) _____

Insured's Name: _____ Birth Date: _____ ID#:_____

Insured's Employer: _____Group #: _____

Relationship to Patient: _____

TREATMENT AUTHORIZATION:

I authorize and give consent to any treatment or procedure or the administration of necessary anesthetics which my dentist deems advisable in my diagnosis and treatment.

Patient or Parent/Guardian Signature: _____Date: _____

Springs Dental

75 Weibel Avenue Unit A

Saratoga Springs, New York 12866

(518) 584-2848

APPOINTMENT CHANGES

I understand that when I make an appointment for myself or my family, I am reserving the staff's time for my own care and that other patients are prevented from taking the time I have chosen.

Therefore, if I wish to change my appointment, I will provide the courtesy of a minimum of 24 hours' notice before doing so, or I agree to pay $50 for the staff's time that I reserved for my care.

TO OUR PATIENTS WITH DENTAL INSURANCE

At Springs Dental we accept many different insurance plans. Each plan is different and they occasionally change their terms of coverage. On occasion, we have been given inaccurate information from different insurance plan clerks. It is your responsibility as the subscriber/patient to know what your plan covers.

We will be happy to assist our patients in obtaining information from insurance companies, however, Springs Dental cannot be held responsible for incorrect information provided to us by these companies.

I accept responsibility for knowing the benefits (coverage) of my insurance plan. I also accept financial responsibility for any fees that are NOT covered by insurance. I understand that payment is due at the time services are rendered.

In the case of overpayments on accounts, credit balances will be applied to future appointments unless a refund is requested in writing.

COLLECTION OF PAST DUE BALANCES

Balances 30 days overdue may be turned over to a collection agency. All costs incurred to collect overdue balances will be paid by the patient including all court and attorney fees.

_____ _____

Patient's name (printed) Signature of patient (or parent, if patient is a minor)

Today's Date _____

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75 Weibel Avenue Unit A

Saratoga Springs, New York 12866

(518) 584-2848

Patient Name _____ DOB_____

HIPAA/PATIENT PRIVACY

Acknowledgement of receipt of Privacy Notice and Release of Protected Health Information. I have been shown/presented with a copy of Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request that the following be adhered to regarding my Protected Health Information. I authorize sending my x rays and referrals to specialists via conventional unencrypted email.

Signature _____ Date_____

Relationship to patient if other than yourself. _____

I do want the following individual(s) to have access to the information checked below (ie: family members, spouse)

- **All Information** **YES _____ NO _____**
- **Financial Information** **YES _____ NO _____**
- **Prescription Information** **YES _____ NO _____**
- **Appointment Information** **YES _____ NO _____**

LIFETIME INSURANCE AUTHORIZATION

I authorize the release of any medical information to process my insurance claims. I request that all payments be made on my behalf and that all benefits are assigned for dental services to Springs Dental. I authorize this request to apply to all services provided after the date below. I understand I am responsible for payment of any balance not paid by my insurance company as outlined in my schedule of benefits and as applicable under law.

Signature: _____ Date: _____

Name: _____ Date: _____

The main reason for your visit today is: _____

How long since your last dental x-rays, cleaning and exam? _____

Why did you leave your previous dentist? _____

What are some of the most important qualities you want in your dentist? _____

_____

	YES	NO	IF YES, PLEASE EXPLAIN
Have you ever had or been treated for gum disease?	☐	☐	
Do your gums bleed on occasion?	☐	☐	
Do you get a bad taste in your mouth?	☐	☐	
Are you missing any teeth, which have not been replaced?	☐	☐	
Do you have children under 15 years old who reside with you?	☐	☐	
Do you object to using laughing gas for your child?	☐	☐	
Do you get pain in or near your ear?	☐	☐	
Does your jaw click or get out of joint?	☐	☐	
Do you clench or grind your teeth?	☐	☐	
Have you ever had braces?	☐	☐	
Does food collect between your teeth?	☐	☐	
Do you have difficulty chewing food?	☐	☐	
Are any of your teeth sensitive to sweets, hot, cold or pressure?	☐	☐	
Do you have any sores, ulcers or swelling in your mouth?	☐	☐	
Have you had any **difficult** extractions or **prolonged** bleeding?	☐	☐	
Are you fearful or apprehensive of having dental work?	☐	☐	
Have you had any difficulties during or from previous dental care?	☐	☐	
Do you have crooked or rotated teeth you wish were straighter?	☐	☐	
Is there anything about the appearance of your teeth that bothers you in any way?	☐	☐	
Would you like your teeth to be whiter?	☐	☐	
Do you prefer natural-looking white fillings for back teeth when necessary?	☐	☐	
If you are very happy with our care, would you kindly show us by referring several relatives, friends or co-workers to us?	☐	☐	
Do you, or have you had dentures or partials?	☐	☐	Year made: Year of last reline:
Do they trap food underneath them or cause soreness?	☐	☐	
Do they have trouble staying in place or bother you in any way?	☐	☐	
Are there any problems or concerns you have, which have not been listed yet?	☐	☐	

Time 12:27 PM

Springs Dental

Eaglesoft Medical History

Date 3/3/2018

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

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:_____