

Eaglesoft Medical History

Patient Name: _____

Birth Date: _____

Date Created: 2/23/2021

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: _____



DePalma Dental

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DENTAL HISTORY

Name: _____ Date of Birth: _____ Referred by: _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist: _____ How long have you been a patient _____ Months / Years

Date of most recent dental exam ____ / ____ / ____ Date of most recent x-rays ____ / ____ / ____

Date of most recent treatment: (other than a cleaning) ____ / ____ / ____

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

Are you fearful of dental treatment? If yes, how fearful, on a scale of 1 (least) to 10 (most)? _____ YES / NO

Have you had an unfavorable dental experience? _____ YES / NO

Have you ever had complications from past dental treatment? _____ YES / NO

Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES / NO

Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ YES / NO

Have you had any teeth removed or missing that never developed or lost teeth due to injury/facial trauma? YES / NO

GUM AND BONE

Do your gums bleed or are they painful when brushing or flossing? _____ YES / NO

Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES / NO

Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES / NO

Is there anyone with a history of periodontal disease in your family? _____ YES / NO

Have you ever experienced gum recession? _____ YES / NO

Have you had any teeth become loose on their own (without injury), or do you have difficulty eating an apple? YES / NO

Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ YES / NO

TOOTH STRUCTURE

Have you had any cavities within the past 3 years? _____ YES / NO

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? YES / NO

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES / NO

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? YES / NO

Do you have grooves or notches on your teeth near the gum line? _____ YES / NO

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES / NO

Do you frequently get food caught between any teeth? _____ YES / NO



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DENTAL HISTORY CONTINUED

BITE AND JAW JOINT

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES / NO

Do you feel like your lower jaw is being pushed back when you bite your back teeth together? _____ YES / NO

Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars, or other hard, dry foods? YES / NO

In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed? YES / NO

Are your teeth becoming more crooked, crowded, or overlapped? _____ YES / NO

Are your teeth developing spaces, or becoming more loose? _____ YES / NO

Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____ YES / NO

Do you place your tongue between your teeth or close your teeth against your tongue? _____ YES / NO

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES / NO

Do you clench or grind your teeth together in the daytime or make them sore? _____ YES / NO

Do you have any problems with sleep (i.e. restlessness or grinding) wake up with a headache or tooth pain? YES / NO

Do you wear or have you ever worn a bite appliance? _____ YES / NO

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? YES / NO

Have you ever whitened (bleached) your teeth? _____ YES / NO

Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES / NO

Have you been disappointed with the appearance of previous dental work? _____ YES / NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



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Referral Information

Whom may we thank for referring you to our practice?

- ☐ **Another patient, friend**
- ☐ **Another Doctor**
- ☐ **Newspaper Ad**
- ☐ **Phone Book**
- ☐ **Work**
- ☐ **TV Commercial**
- ☐ **Internet Search**
- ☐ **Other**

Name of person or office referring you to our practice:

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient) _____

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Pre Med _____
Emergency Contact _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____



FINANCIAL POLICY AND DENTAL INSURANCE EXPLANATION

Thank you for choosing DePalma Dental, LLC as your dental care provider! We are committed to providing the best dental care and service possible. It is also our goal to effectively communicate with our patients on all levels. With this in mind, please read the information regarding our policy on appointments and dental insurance benefits. If you have any further questions, please do not hesitate to ask.

CANCELLATION POLICY / RESERVED APPOINTMENT TIMES:

It has always been our contention that your time is valuable. We have a theory about scheduling - you deserve our undivided attention. For this reason, we do not double-book like other practices, and we also do not accept walk-ins. When we schedule a dental visit, that time is yours. It belongs to you. We understand that sometimes you are unable to make an appointment after you schedule it, however, when that appointment is cancelled within 24 hours of the appointment, it does not allow us enough time to replace it with someone who is also in need of our services.

To ensure availability for all patients, appointments must be confirmed by 11 am on the business day prior to the scheduled visit or they will be canceled.

If this occurs there will be a charge of \$50.00 made to your account. We will consider exceptions on an individual basis. Please sign below stating that you understand our cancellation policy and will work together with our office to continue providing you with prompt care.

NEW PATIENT CANCELLATION POLICY

As stated above our patients deserve our undivided attention. Appointments are held special for you and are never double booked. If appointments are missed or canceled within 24 hours, the full new patient appointment charge of \$432 will be charged to your account. Please be mindful to the time we have reserved for you. We will consider exceptions on an individual basis.

INSURANCE

The insurance you have is a contract between you, your employer (if applicable) and the insurance company. Your employer has selected the level of insurance coverage you have. Covered services vary from plan to plan. Insurance companies base the amounts that they will pay for your dental treatments on restricted fee schedules related to your premium payments and geographical locations. Dental insurance is designed to defray the cost of your dental treatment. It is not intended as a total payment for services and should not be used to determine the type or amount of treatment you receive.

Please understand:

You must provide our office with a valid insurance card.

You must understand the terms of YOUR insurance coverage including but not limited to

1. Waiting periods for certain treatments
2. Changes in your plan terms/benefits (insurances do not tell us if there is a change)
3. Limitations and exclusions on certain treatment
4. Other benefits used in other dental offices

DO YOU ACCEPT MY INSURANCE?

If your insurance plan allows you the freedom to choose your own doctor, then you can use your benefits in our office. We are happy to file your claim for you.

HOW MUCH WILL THEY PAY?

Please call your insurance company to find out what your out-of-network benefits are and what they will cover for an out-of-network provider.

INSURANCE DIDN'T PAY NOW WHAT?

Ultimately, you are responsible for all charges incurred in our office. We file your primary insurance claim as a courtesy to you. We will try to submit the claim again if other information or questions are asked by the insurance company.

If you have any questions about our financial policy or have any uncertainty regarding insurance coverage, please ask now.

I have read and understand the above financial and cancellation policy and agree to comply with its terms.

Print Name: _____ Signature: _____

Date: _____



HIPAA - Patient Consent Form

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment of health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have to the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following: a) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment; i.e. release of radiographs and or treatment plans to referring physicians and or dentists) b) Obtaining payment from third party payers (i.e. my insurance company) c) The day-to-day healthcare operations of our practice.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Kristina Kelly. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name: _____ **Signature:** _____

Parent/Guardian Signature: _____

Date: _____

If you would like us to share any information with a family member/caregiver, list their name below: