ADVANCED
DENTISTRY
BY JAMES BLANK

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

Preferred Name:_____ E-mail:_____

Mailing Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth Date:_____ Social Security #:_____ Sex: ○ Female ○ Male

Preferred Pharmacy:_____

Referred By:_____

Responsible Party:

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

Mailing Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth Date:_____ Social Security #:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child

Employer ID:_____

Insured Social Security #:_____ Insured Birth Date:_____

Employer:_____ Insurance Company:_____

Secondary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child

Employer ID:_____

Insured Social Security #:_____ Insured Birth Date:_____

Employer:_____ Insurance Company:_____

IN CASE OF EMERGENCY :

Contact:_____

Phone Number:_____

James E. Blank, DDS, LLC

Eaglesoft Medical History

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

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:_____

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Financial Policy

Thank you for choosing us to provide your dental care. It is our goal to provide the finest quality dental care to our patients and their families. Your understanding of our office policies is important to our professional relationship.

Required at each visit:

- Provide current personal information at each visit
- Provide current insurance card at each visit
- Payment of any outstanding balance
- Payment for today's visit (Fees / Co-pays / Deductibles)

Insurance Plans:

Your insurance plan is a contract between you, your employer and the insurance company. We are not a party to that contract. While the filing of insurance claims is a courtesy that we extend to you, all of the patient charges are your responsibility from the date that the services are rendered. We do ask that you pay the estimated charges at the time of service. We will bill your insurance for their portion of payment, and any overpayment will be refunded to the responsible party. Also, additional payment needed after the collection of insurance benefits will be billed to the responsible party and are due 30 days from the statement date.

Methods of Payment:

Cash/Check – If you make your payment in full at the time of service, we will allow a 7% courtesy for payment by cash or check.

Credit Cards – We accept Visa, MasterCard, Discover and American Express. If you pay for your services in full at the time of service with a credit card we will allow a 5% courtesy.

Dental Fee Plan (CareCredit, Lending Club) – Outside source of financing for your dental treatment. Please ask us for details.

*Payment plans are available for orthodontic treatment. Please ask for details.

All balances over 90 days overdue are subject to a 6% finance charge, with a maximum yearly finance charge of 24.99%. The minimum monthly finance charge will be $4.00.

There will be a $30 cancellation fee for appointments cancelled less than 24 hours in advance. There is a $30 returned check fee due to bank charges to our office.

Signature _____Date_____

Thank you,

James E Blank, DDS

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GENERAL • RESTORATIVE • COSMETIC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____

Address:_____

Home Phone:_____Work Phone:_____Cell:_____

E-Mail:_____ Social Security Number:_____

I have had the opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date:_____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will ***not*** affect in any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.