Patient Medication List

Patient Name	Date of Birth	Sex Male Female
Allergies/Adverse Reactions to Medications	Pharmacy Name	Pharmacy Number

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids, vitamins) and herbals (examples: gingseng, ginko). Include medications taken as needed (example: nitroglycerin).

Name of Medicine	Dose (mg, puffs, drops)	Schedule (times per day)

Time 10:57 AM

Belmont Dental Associates

Date 9/19/2017

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, c

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:_____

BELMONT DENTAL

1212 Spruce Street, Suite 201
Belmont, NC 28012 I 704-825-3455
Belmont-Dental.com

Thank you for choosing Belmont Dental Associates as your dental provider! To help us meet your entire dental healthcare needs, please fill out these forms *completely*. If you need any assistance or have any questions, please ask and we'll be happy to help!

Referrals are important to us! Please tell us how you heard about us:

☐ Google ☐ Direct Mailer ☐ Insurance ☐ Facebook ☐ Twitter ☐ Other_____

If referred by a patient/relative, whom may we thank for referring you: _____

How do you prefer to be contacted? ☐ Cell phone ☐ Home phone ☐ Email ☐ Other_____

Patient Information

Name: Preferred Name: _____ Sex: M F

Address: Home Phone: _____

City: State: Zip: _____ Cell Phone: _____

Patient SSN: Date of Birth: Work Phone: _____

Email:

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient or Parent/Guardian Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: ZIP: _____

Emergency Contact: _____ Phone: _____

Responsible Party Information

Person responsible for account: _____ Date of birth: _____ SSN:

Address: _____ City: State: ZIP: _____

Phone: _____ Email: _____ Relationship to Patient: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ DOB: _____

Insurance Company: _____ Name of Employer: _____

Policy/ID Number: _____ Group Number: _____ Insurance Phone Number: _____

Patient/Responsible Party Signature: _____ **Date:** _____

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FINANCIAL AGREEMENT

Thank you for choosing Belmont Dental Associates as your dental provider. Please understand that a financial agreement is an important part of the provider-patient relationship.

INSURANCE

We file insurance claims as a courtesy to you at no charge, and although we are on several Preferred Provider lists, **any insurance company can designate a procedure as "not covered".** There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type of plan chosen by you and/or your employer and we are not party to this. We have no control over the terms of your contract or the determination of your benefits.

Your insurance company does not guarantee any payment of services until the claim we submit has been received and reviewed. Therefore, your portion of services performed in this office are only an ESTIMATE and due payable at the time of service. Even a preauthorization of services does not guarantee payment from your insurance carrier.

Once the Explanation of Benefits (EOB) is received, our office will notify you if your plan denied the procedures or paid less than we anticipated. Charges that are denied by your insurance company are your responsibility. If you have questions regarding this action, you should contact your employer or the insurance company directly for an explanation. Covered procedures differ from plan to plan and it is impossible for us to know the details of each plan. Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise.

Once the annual maximum has been reached, **you are fully responsible for ALL treatment completed.**

Dental insurance has a deductible and yearly limit. Please familiarize yourself with your plan's specifics and notify us as soon as possible when any changes are made.

The ultimate responsibility of payment for services is with you.

DISCOUNTS

In-network patients who are receiving in-network fees are prohibited from receiving any additional discounts. A 5% discount only applies to out-of-network/non-insurance patients whose **treatment is paid in full by cash**.

We accept cash, Visa, MasterCard, Discover, and American Express. We also offer financing of treatment through CareCredit.

I have read and understand the above financial agreement.

Signature: _____ Date: _____

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GENERAL CONSENT FORM

Patient Name: _____ Date of Birth: _____ SSN: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

I do hereby authorize and request the performance of dental services Belmont Dental Associates may deem necessary for my treatment. I understand that Belmont Dental Associates will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics that may be deemed appropriate by Belmont Dental Associates. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic or for treatment of facial pain. I understand that potential complications include but are not limited to pain, swelling, bruising, temporary limited opening and local infection. I understand that in occasional cases the anesthesia may prolong and in very rare cases cause permanent numbness.

I understand that I am responsible for obtaining any current X-rays that may have been taken at a previous dental office.

I understand that any treatment plan presented, along with the fees outlined, could change depending on the time elapsed since initial examination and extent of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedure or treatment. Belmont Dental Associates will always advise me of any changes. I understand my relevant personal health information may be released to my insurance company in order to get reimbursement.

In the event that Belmont Dental Associates is exposed to my blood or bodily fluids, I agree to have my blood drawn and tested for Hepatitis B, Hepatitis C and the Human Immunodeficiency Virus. I understand that testing would be done in a confidential manner, and would be made available only to the person who was exposed and that person would be advised of my rights regarding protected health information.

Patient Signature: _____ Date: _____

Signature of Parent, Guardian or Personal Representative: _____

Relationship: _____

You are entitled to a copy of this consent after you sign it

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APPOINTMENT AGREEMENT

We make every effort to value your time and we schedule your appointment just for you. We are committed to your oral health and keeping your reserved time allows us to be partners in your dental care.

We ask that you confirm your appointment a minimum of 2 business days prior. You may confirm via text, email or by calling our office during normal business hours. Failure to confirm your appointment may result in the loss of the time reserved for you and your treatment. Please note that we do not accept cancellations via our answering machine.

Missed Appointments: Any appointment that the patient does not keep or any appointment the patient cancels/changes within 2 business days' notice.

We will not charge for your first missed appointment. However, there will be a $50.00 charge for a second missed appointment within a 12 month time span. At this time, you will be required to pay ahead when scheduling your next appointment. If you keep the appointment, the payment will be applied towards your treatment. However, if you fail to keep the appointment, the deposit will be forfeited.

Appointment Agreement

- I agree to provide a minimum of 2 business days' notice if I need to change my appointment for any reason
- If I change my appointment without the required 2 business days' notice within in a 12 month span, I acknowledge I may be asked to prepay at the time of scheduling in order to be appointed.
- I understand that I must confirm my appointment 2 business days' prior to my appointment or forfeit the appointment made for me and any and all deposits.

Patient Signature: _____ Date: _____

DISMISSAL POLICY

When patients no show, cancel at the last minute, or show up late for their appointment, it greatly effects our schedule, as well as other patients appointments. In the event that you have more than 2 broken appointments, late cancellations, or frequently show up late for your appointment, you may be dismissed from our practice. Our voicemail does not accept any cancellations or changes to appointments; you will need to call back during normal business hours.

We also ask that you abide by the following rules while in our office so that we can service your dental needs in the best way possible:

- Cell phones are not to be used in the office. Please step outside if you need to make a call
- If you are more than 15 minutes late for your appointment, you may have to reschedule
- When you are late, it counts towards our dismissal policy
- If you do not have someone to watch your child/children that are under the age of 5, you will need to reschedule your appointment

I understand my responsibilities as outlined above and will abide by them.

Patient's Name: _____ Date: _____

Patient/Guardian Signature: _____

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ACKNOWLEDGMEN OF RECEIPT – NOTICE OF PRIVACY PRACTICE

Our "Notice of Privacy Practices" document provides detailed information about the use and disclosure of your protected health information. You have the right to review the "Notice of Privacy Practices" document prior to signing this consent form.

I, AS THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE, have received a copy of Belmont Dental Associates "HIPAA NOTICE OF PRIVACY PRACTICES" document. If this acknowledgement of receipt is not obtained (i.e. emergency treatment situation), Belmont Dental Associates representative (witness) MUST document his/her good faith efforts to obtain the acknowledgment and the reason it was not obtained.

Signed: _____ **Date:** _____
Patient, Parent/Guardian, Personal Representative

GOOD FAITH EFFORT AND REASON ACKNOWLEDGMENT WAS NOT OBTAINED (documented by Belmont Dental Associates)

_____Patient refused to sign _____Patient unable to sign ____Other: _____

PERSONAL REPRESENTATIVE AUTHORIZATION

A personal representative is anyone that you would like Belmont Dental Associates to release your patient information to, including, but not limited to, prescription refills and/or samples, reasons for a particular visit, billing information, etc. If there are no names listed below, we are assuming that you are declining your option to choose a personal representative. Upon doing so, please keep in mind that our office will not give out any information, including prescription refills, to anyone other than the patient or patient guardian.

- o I **DO NOT** wish to select a personal representative
- o I authorize the following individual(s) to serve as my/patient's Personal Representative with full authority to access or authorize, review, release and/or copy my/patient's medical records

1) _____ 2) _____

3) _____ 4) _____

- o I authorize Belmont Dental Associates to leave detailed information in my voice mail
- o I **DO NOT** authorize Belmont Dental Associates to leave detailed information in my voice mail

I may revoke this request in writing at any time except to the extent that action based on this authorization has already taken place.

Signed: _____ **Date:** _____
Patient, Parent/Guardian, Personal Representative