CRAIG A. FEDORE, D.D.S., P.C.
BRIAN M. GRISDELA, D.D.S.
AYA ZAKY, D.D.S.

714 ABBOT ROAD, EAST LANSING, MI 48823
PHONE: 517-337-0351 FAX: 517-337-5610

On behalf of our team, welcome to our office. We are pleased that you have chosen us to care for your dental needs and assure you we are committed to providing you and your family with safe, high quality healthcare. The treatment we recommend for you is based upon what we would recommend for members of our own families under similar circumstances.

During your first visit a thorough examination will be conducted. This will include updating any x-rays and other aids that may be needed to accurately diagnose the condition of your mouth, teeth and gums. We can determine your dental needs and discuss suggested treatment with you. Usually, a cleaning is done at this time; but since all patients have treatment plans based on their individual needs, we have found that this is not possible with some of our new patients.

Unless emergencies dictate otherwise, you can expect us to be on time for you. **If you need to reschedule an appointment, please give us a 24 hour notice so that your time may be given to another patient. If you no show or late cancel, we may bill your account $40 depending on the circumstances.**

Our payment policy is:

*Cash or check at the time of treatment (co-payment if there is insurance involved)
*Mastercard/Visa/ American Express accepted
*Carecredit accepted
*Most insurances accepted

Insurance makes life easier. We do accept dental insurance, but it is important for you to know that these dental benefits vary considerably in the arbitrary fees set by insurance companies and chosen by your employer. If your dental benefits require a "prior authorization" our office will submit a treatment plan for review by your insurance carrier. We also will be happy to bill your insurance company, however, it is important that you realize **THE ENTIRE FEE WILL BE THE RESPONSIBILITY OF THE INDIVIDUAL PATIENT.** The insurance company is responsible to you and not this office.

Again, we are committed to responsible healthcare and look forward to seeing you.

Sincerely,

Craig A. Fedore, D.D.S., P.C., Benjamin S. Jamo, D.D.S., Aya Zaky, D.D.S., & Team

Signature:_____ **Date:**_____

Time 12:13 PM

CRAIG A. FEDORE, D.D.S.,P.C.

Date 2/11/2019

Patient Name:

Eaglesoft Medical History

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

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:_____

TIME 03:00 PM

DATE 2/25/2019

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:

Home Phone: Work Phone: Ext: Pager: 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:

Home Phone: Work Phone: Pager:

Sex: ☐ Male ☐ Female Ext: Cellular:

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

PHARMACY NAME

PHARMACY PHONE

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:

East Lansing Family Dentistry

Authorization Form for Release of Protected Health Information For Non-Treatment, Payment or Operations (TPO)

Patient Name_____ Patient's Date of Birth_____

I hereby authorize the use and disclosure of individually identifiable dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific Description of Information to Be Used or Disclosed:

_____

_____

Purpose for Disclosure: _____

I authorize the following person(s) to make the requested use or disclosure of the above health information.

_____

_____

Person(s) Receiving My Authorized Information Include_____

_____

I understand that I may revoke this authorization at any time by notifying _____ in writing. If I choose to do so, my revocation will not affect any actions taken by _____ before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This Authorization Expires on _____

Signature of Patient or Patient's Personal Representative

_____Date_____

If Personal Representative
Print Name_____

Signature _____Relationship to Patient_____

For office use only: Copy of signed authorization provided to the individual: Date:_____ Initials_____.

File this form in the patient's chart or electronic record.