Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Pillsbury Dental Associates
125 Greentree Dr., Dover, Delaware 19904
www.Pillsburydentalassociates.com
(302) 734-0330
FAX (302) 674-8218

PATIENT INFORMATION

Dr. Mr. Mrs. _____ ☐ Female ☐ Male
Ms. Miss Rev. *Last* *First* *Middle*

Address _____ Birth Date ____/____/____ SS#_____
City, St, Zip _____ Home #_____ Cell # _____
Drivers Lic #/State _____/_____ ☐ Home ☐ Work E-mail: _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow May we send e-mails? _____

Employer _____ Business #_____ Extension _____
Employer Address _____
City, St, Zip _____

Spouse Name _____ Birth Date ____/____/____ SS#_____
Spouse Employer _____ Cell # _____
Employer Address _____ Business #_____ Extension _____
City, St, Zip _____

Nearest Relative Not Living with You _____ **Emergency Contact Name**
Relationship _____ Phone # _____ _____
Mailing Address _____ Emergency Contact Phone # _____
City, St, Zip _____ Emergency Contact Work # _____

Is patient a college student? ☐ Yes ☐ No Mother's Work # _____
School _____ Graduation Year _____ Father's Work # _____

Preferred Day/Time for Appointment: Day(s) _____ Time: _____ AM PM

RESPONSIBLE PARTY ☐ *See Information Above*

Subscriber's Name _____
Subscriber's Address _____
City, St, Zip _____
Relationship _____ Home # _____
Birthdate ____/____/____ SS#_____
Subscriber's Employer _____
Employer Address _____
City, St, Zip _____
Business # _____ Extension _____

DENTAL BENEFIT PLAN CARRIER

Carrier Name_____
Address _____
City, St, Zip _____
Phone # _____ Ext. _____
Policy # _____
Group # _____
Plan # _____
Effective Date of Coverage _____
Does patient have other dental coverage? ☐ Yes ☐ No
If yes, name of carrier_____

Time 10:38 AM

Pillsbury Dental Associates, LLC

Eaglesoft Medical History

Date 8/11/2015

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:_____

DENTAL HISTORY

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 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
8. Have you ever whitened (bleached) your teeth? _____	☐	☐
9. Are you self conscious about your teeth? _____	☐	☐
10 Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT		
11. Do you / would you have any problems chewing gum? _____	☐	☐
12. Do you / would you have any problems chewing bagels or other hard foods? _____	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
14. Are your teeth crowding or developing spaces? _____	☐	☐
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____	☐	☐
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
18. Do you have tension headaches or sore teeth? _____	☐	☐
19. Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years? _____	☐	☐
21. Do you have a dry mouth? _____	☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets? _____	☐	☐
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	☐	☐
24. Do you avoid brushing any part of your mouth? _____	☐	☐
25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____	☐	☐
GUM AND BONE		
26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
27. Have you ever experienced gum recession? _____	☐	☐
28. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
29. Do your gums bleed when brushing, flossing or eating? _____	☐	☐
30. Are your teeth becoming loose? _____	☐	☐
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
32. Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

following policies and procedures.

PAYMENT POLICY : Payment is due at the time services are rendered. If you have dental insurance, your co-pay plus deductible is due at the time of service.

1. We accept cash, personal checks with proper ID , money orders, Debit cards, Visa, MasterCard, Discover & American Express.
2. We require a 50% reservation fee on all work other than preventative appointments
3. Any outstanding balance after 90 days may be referred to an outside collection agency. You will be responsible for any and all costs incurred in the collection of your debt.
4. Financing available through Care Credit with prior approval
5. A $35 fee will apply for any checks returned by the bank
6. **MINOR PATIENTS:** In the case of divorced or separated parents, it is **YOUR** responsibility to have financial arrangements made according to the divorce decree before treatment begins.
7. If there is ever a request for records transfer there will be a $25.00 fee

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree with the following:

1. You must provide us with an insurance card and/or all of the information necessary to verify your coverage and file your claim.
2. Your insurance policy is in contract between you , your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
3. You are responsible to pay our fees; not what your insurance company allows and consider "usual, customary and reasonable" (UCR), all of which vary from one company to another.
4. Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance and responsibility to pay regardless of our estimate.
5. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services provided are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.
6. Treatment provided in another dental office during your current plan year may alter your co-payment due to services in our office. In such case we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.
7. There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but CANNOT guarantee what your out of pocket expense will be.
8. Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations.

   BROKEN OR MISSED APPOINTMENTS: To reschedule or cancel an appointment, you must notify us at least 24 hours (business day) in advance to avoid a missed fee of up to $50.00 (fee based on appointment length and/or number of appointments missed). Missed or broken appointments prevent others from receiving dental care they deserve. We do not accept cancelations on our machine after business hours, we must speak with you.

1. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

   I have read and understand this document in its entirety; outlining the office and financial policies of Pillsbury Dental Associates and agree to these terms.

Signature of patient or parent/guardian: _____

Date:_____

Pillsbury Dental Associates
ACKNOWLEDMENT OF RECIEPT
HIPPA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Representative

Authority of Personal Representative to sign for Patient (check one)

- o **Parent**
- o **Guardian'**
- o **Power of Attorney** _____

The front desk has a copy of the HIPAA Notice of Privacy if you would like to obtain a copy.

- **Please Note: It is your right to refuse to sign this Acknowledgement**

Dental Office Use Only

I tried to obtain written Acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

__ an emergency prevented us from obtaining the acknowledgement.

__ a communication barrier prevented us from obtaing acknowledgement.

__ the individual was unwilling to sign.

__ Other: _____

_____ _____

Staff Member Signature Date

Pillsbury Dental Associates

HIPAA AUTHORIZATION FORM

I, _____, hereby authorize the use or disclosure of my protected Health information, medical records, account information and any other information regarding my dental health to the following persons:

Name: _____

DOB: _____

Name: _____

DOB: _____