

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 Address	Middle Birth Date/ SS# Home # Cell #
City, St, Zip Drivers Lic #/State/	☐ Home ☐ Work E-mail:
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow	May we send e-mails?
Employer Address City, St, Zip	Business #Extension
Spouse Name	A 11 11
Spouse Employer Employer Address City, St, Zip	Business # Extension
Nearest Relative Not Living with You Relationship Phone #	Emergency Contact Name
Mailing Address City, St, Zip	Emergency Contact Phone #Emergency Contact Work #
Is patient a college student? ☐ Yes ☐ No School Graduation Year	Mother's Work #
Preferred Day/Time for Appointment: Day(s)	Time: AM PM
RESPONSIBLE PARTY See Information Above Subscriber's Name Subscriber's Address	Carrier Name Address
City, St, Zip Home #	City, St, ZipExtExt
Birthdate/ SS#Subscriber's Employer	Group #
Employer Address City, St, Zip	Effective Date of Coverage
Business # Extension	Does patient have other dental coverage? ☐ Yes ☐ No If yes, name of carrier

X

Patient Name:

Pillsbury Dental Associates, LLC **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. OYes ONo If yes Are you under a physician's care now? Have you ever been hospitalized or had a major OYes ONo If yes operation? Have you ever had a serious head or neck injury? OYes ONo If yes O Yes O No Are you taking any medications, pills, or drugs? If yes Do you take, or have you taken, Phen-Fen or Redux? OYes ONo If ves O Yes O No If yes Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No Are you on a special diet? Yes \(\)No Do you use tobacco? Women: Are you... Nursing? Taking oral contraceptives? Pregnant/Trying to get pregnant? Are you allergic to any of the following? ☐ Acrylic ☐ Codeine Aspirin Penicillin Local Anesthetics Sulfa Drugs Metal Latex If yes Other? O Yes O No If yes Do you use controlled substances? Do you have, or have you had, any of the following? O Yes O No O Yes O No OYes ONo Radiation Treatments Hemophilia O Yes O No Cortisone Medicine AIDS/HIV Positive O Yes O No OYes ONo OYes ONo Recent Weight Loss OYes ONo Hepatitis A Diabetes Alzheimer's Disease O Yes O No O Yes O No OYes ONo OYes ONo Hepatitis B or C Renal Dialysis Anaphylaxis Drug Addiction O Yes O No OYes ONo OYes ONo O Yes O No Rheumatic Fever Easily Winded Herpes Anemia OYes ONo O Yes O No OYes ONo Rheumatism OYes ONo Emphysema High Blood Pressure Angina O Yes O No OYes ONo OYes ONo Scarlet Fever OYes ONo Epilepsy or Seizures High Cholesterol Arthritis/Gout O Yes O No O Yes O No OYes ONo Shingles Hives or Rash OYes ONo Excessive Bleeding Artificial Heart Valve OYes ONo OYes ONo O Yes O No Sickle Cell Disease OYes ONo Excessive Thirst Hypoglycemia Artificial Joint OYes ONo Fainting Spells/Dizziness Yes No O Yes O No Sinus Trouble OYes ONo Irregular Heartbeat **Asthma** O Yes O No OYes ONo Spina Bifida O Yes O No OYes ONo Kidney Problems Frequent Cough Blood Disease OYes ONo Stomach/Intestinal Disease O Yes O No OYes ONo OYes ONo Frequent Diarrhea Leukemia **Blood Transfusion** O Yes O No OYes ONo O Yes O No Stroke OYes ONo Liver Disease Frequent Headaches Breathing Problems O Yes O No Low Blood Pressure OYes ONo O Yes O No OYes ONo Swelling of Limbs Genital Herpes Bruise Easily O Yes O No OYes ONo OYes ONo Thyroid Disease O Yes O No Glaucoma Lung Disease Cancer O Yes O No O Yes O No O Yes O No Tonsillitis O Yes O No Mitral Valve Prolapse Chemotherapy Hay Fever OYes ONo O Yes O No O Yes O No O Yes O No Heart Attack/Failure Osteoporosis Tuberculosis Chest Pains O Yes O No OYes ONo OYes ONo Tumors or Growths Cold Sores/Fever Blisters O Yes O No Pain in Jaw Joints Heart Murmur O Yes O No O Yes O No O Yes O No OYes ONo Parathyroid Disease Congenital Heart Disorder Heart Pacemaker OYes ONo OYes ONo Venereal Disease Heart Trouble/Disease OYes ONo Convulsions OYes ONo Psychiatric Care O Yes O No Yellow Jaundice Have you ever had any serious illness not listed O Yes O 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: Date:

DENTAL HISTORY

PLEASE ANSWER YES OR NO TO THE FOLLOWING: PERSONAL HISTORY 1. Are you fearful of dental treatment? Scale of 1 to 10 (very) 2. Have you faid an uniforonable dental experience? 3. Have you ever had complications from past dental treatment? 4. Have you ever had complications from past dental treatment? 5. Did you ever have fornees, orthodorrist treatment or had your bite adjusted? 6. Have you had any teeth removed? 7. Is there anything about the appearance of your teeth that you would like to change? 8. Have you ever whitened (blooched) your teeth? 9. Are you self consolus 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 tagels or other hard foods? 12. Have you teeth orwarding or the last 5 years, become shorter, thinner or worm? 13. Have your teeth changed in the last 5 years, become shorter, thinner or worm? 14. Are your teeth changed in the last 5 years, become shorter, thinner or worm? 15. Do you have more than one bits or do you dend; (squeeze) to make your teeth? 16. Do you have any problems with your jaw joint? (pains, sounds, limited opening, locking, popping) 17. Do you wear or have you ever worm a bits appliance? 18. Have you weet most had not become so rose teeth? 19. Do you have and yrmouth? 20. Have you see the sinch haddones or sore teeth? 21. Do you have any problems with your jaw joint? (pains, sounds, limited opening, locking, popping) 22. Are any teeth sensitive to hot, cold, biting or swets? 23. Have you ever whad a tootafach, cracked filling, broken, chipped or cracked tooth? 24. Do you have any rowothers with in the past 3 years? 25. Do you feel or notice any holes (i.e. pitting) in your teeth? 26. Have you ever been diagnosed or treated for periodontal (gum) disease? 27. Have you ever been diagnosed or treated for periodontal (gum) disease? 28. Have you ever been rolling any part of your mouth? 29. Do your gums bleed when brushing, flosses in your family? 20. Are your teeth becom	Pre Da Da	Referred byHow would you rate the condition of your mouth?				
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following policies and procedures.

<u>PAYMENT POLICY</u>: 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

<u>DENTAL INSURANCE:</u> 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
 - 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 Namo (Please Print) Date Patient Signature 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 deak 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

	, hereby authorize the use or disclosure of my protected Health
information, medi	cal records, account information and any other information regarding my denta
health to the follo	wing persons:
Name:	
DOB:	
Name:	
DOB.	