TIME 12:14 PM

DATE 7/29/2019

# 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: Pager:

Home Phone: Work Phone: Ext: 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: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female 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

emergency contact

emergency phone #

Credit Card

Who Referred You:

## 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:

Time 12:15 PM

GoSmiles Gainesville

Date 7/29/2019

## Eaglesoft Medical History(Copy)

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 |
| Do you need to Pre-Medicate Before a Dental Visit? | ○ 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 | Tonsilitis ○ 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:_____

# GoSmiles Dental

## FINANCIAL AND DENTAL INSURANCE POLICY

We appreciate the opportunity to provide quality dental care to you and your family and we welcome you to our dental family. We would like to acquaint you with our policies regarding dental insurance, financial arrangements, and possible schedule changes.

Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options. You may choose from the following options that would best suit your needs.

1. Equal payments- equal payments will be determined by the number of visits for each treatment. (First payment due at the start of treatment, second payment due at the second dental visit and thus forward).
2. For your convenience, we have made arrangements to accept payment by ***all major credit cards***.
3. Monthly payments- If you need to make monthly payments we offer a safe and secure website to process your payments once a month approved by the office prior to treatment.

Our office fees reflect the commitment and quality of care that our patients deserve. If you have dental insurance, as a courtesy we will complete all the necessary information and submit on your behalf to your primary insurance. ***Your estimated co-payment*** will be due at the time of service unless other arrangements are made with the office. ***Unless we are a participating provider with the carrier, any secondary coverage is the responsibility of the insured.***

If your dental carrier has not made a payment within 60 days of billings, the balance will become your responsibility. You will be billed for any balance due. Insurance coverage is a contractual agreement between the insurance company and you and/or your employer.

We reserve the right to apply a billing charge of ***1.5% (18% APR)*** on all accounts ***90 days*** overdue.

A $32.00 service charge will be added to your account for each returned check to our office due to insufficient funds. If at any time these fees change at our financial institution you are responsible for the current fees for returned checks.

I have read and understand fully the financial options. I understand that in the event my account becomes delinquent I will be responsible for any collections FEE (30%), attorney fees, court cost, and any other charges incurred to collect the account.

_____ _____

Signature of Responsible Party Date

# GoSmiles Dental

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OUR HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

**Go Smiles** will use and disclose your personal information to treat you, to receive payment for care we provide, and for other health care operations. Heath care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regard to protected health information. The terms of this notice may change with time, and we will have copies available for distribution. I acknowledge that I have received, read and understand the **NOTICE OF PRIVACY PRACTICES**.

I also give Go Smiles permission to speak to the following people (if any) regarding my health information.

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Patient Name Signature of Patient/Responsible Party

_____

Date

# BROKEN APPOINTMENT POLICY

GoSmiles Dental knows your time is valuable. In fact, we make it a point to schedule all of our patients with respect to your busy schedule. Our daily goal is to seat all of our patients on time. In an effort to provide timely service to our patients we never over-book our schedule like so many other health care facilities. This commitment to your time makes our time very valuable to us as well.

Therefore, the following is the broken appointment policy:

1. All cancellations or rescheduling of appointments must be arranged 48 business hours prior to appointment date.

2. If a broken or cancelled appointment occurs with less than 48 business hour notice, we will apply a $50 fee to your account.

Thank you for understanding how valuable we consider your time.

_____ _____

Patient / Guardian Signature Date