Harrisonburg
FAMILY & COSMETIC DENTISTRY
Mario DeNicola, DDS • Monisha Khanna, DDS • Douglas Wright, DDS

About You

Patient Name: _____
Patient nickname: _____
How did you hear about us? _____
Today's date: _ ___/___ _/____
Male: _____ Female: _____
Birthdate: ____/_____/_____ Age: _____
Patient SSN: _____
Mailing address: _____

_____
Home phone: _____
Cell phone: _____
Work phone: _____
Email address: _____
Marital Status: _____
Spouse's name: _____
Spouse's phone: _____

In the event of an EMERGENCY:
Whom should we contact: _____
Home phone phone: _____
Cell phone phone: _____
Work phone: _____

Account information

Person responsible for account payment
Name: _____
Relation: _____
Address: _____

_____
SSN: _____
Birthday: ____/____/_____
Home phone: _____
Cell phone: _____

Preferred payment method: Cash Check Credit Card

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

Insurance information

Primary Dental insurance
Insurance Co: _____
Address: _____

_____
Phone: _____
Insured's ID: _____
Group #: _____
Policyholder name: _____
Relation: _____
Policyholder Birthdate: _____/_____/_____
Policyholder SSN: _____
Insured SSN: _____
Insured's employer: _____

Secondary Dental insurance:
Insurance Co: _____
Address: _____

_____
Phone: _____
Insured's ID: _____
Group #: _____
Policyholder name: _____
Relation: _____
Policyholder Birthdate: _____/_____/_____
Policyholder SSN: _____
Insured SSN: _____
Insured's employer: _____

Medical Insurance information:

Insurance Co: _____
Address: _____

_____
Phone: _____
Insured's ID: _____
Group #: _____
Policyholder name: _____
Relation: _____
Policyholder Birthdate: _____/_____/_____
Policyholder SSN: _____
Insured SSN: _____
Insured's employer: _____

Appointment policy

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved a time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may accommodate other patients in need. We reserve the right to charge $50.00 per hour for a 1st missed appointment without proper notification, and $100.00 for the 2nd missed appointment. **You must speak to a team member to change or cancel an appointment.**

Financial policy

Payment Options

1. For your convenience we accept Cash, Check, Visa, Master Card, Amex and Discover.
2. Care Credit – short and long-term financing options that include interest free terms up to 12 months and extended terms with interest.
3. Health Credit Services Loans--financing options for larger treatment plans
4. We offer a prepayment courtesy of 5% on restorative treatment over $1,000.00 that is paid for prior to an appointment.

For Patients with Dental Insurance

- Dental Insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental service provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during the treatment plan presentation. We do our best to give you an accurate estimate and there are also times that your insurance carrier remits payment to you rather than our office.

For Patients with Medical Insurance

- For certain procedures and medical insurances, we may be able to use medical benefits to help with your needed dental treatment. Please ask a front office team member if you are eligible.

Finance Charges and Fees

- Balances in excess of 60 days are subject to a monthly finance charge of 1.5%.
- Returned checks are subject to a $35 accounting fee.

General Consent to Treat

I agree and consent to a dental examination by the dental professionals at Harrisonburg Family & Cosmetic Dentistry. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Wright to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Wright.

I Understand and Will Comply With:
The appointment policy, financial policy, general consent to treat and release of information policies listed above.

****I HAVE BEEN OFFERED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.****

X_____ Date_____

Patient/Responsible Party Signature

Time 11:09 AM | Harrisonburg Family _Cosmetic Dentistry | Date 11/9/2017

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, 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:_____