PATIENT INFORMATION UPDATE

Today's Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

Home Phone Number: _____

Cell Phone Number: _____

Do you want to receive text confirmations/communication from us? Yes _____ No _____

Work Phone Number: _____

Email Address: _____

Do you want to receive Emails from us? Yes _____ No _____

Home Address: _____

Mailing Address: _____

Preferred Pharmacy: _____

Insurance Information (If Applicable)

Insurance Company: _____

Name of Policy Holder: _____

Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Policy Holder's Employer: _____

_____
Patient/Responsible Party Signature

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST TO MAKE A COPY

Revised 10-16-2020

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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:_____

Collinsville Dental
ASSOCIATES
www.collinsvilledentalassociates.com
4940 Kings Mountain Road · Collinsville, VA 24078 · (276) 647-1494

Financial Policy for Patient Care Services

To help provide the most efficient and reasonable health care services, it is necessary for us to have a *Financial Policy* stating requirements for payment of services provided to our patients. Patients are ultimately responsible for the payment of all services provided by our office.

DENTAL INSURANCE AND PATIENT CONSENT:

- As a courtesy, our office will file a claim with your primary insurance carrier on the date of service. We can assist you with secondary coverage. By signing below, you are authorizing our office to submit these claims on your behalf, along with any xrays or treatment information needed for insurance to approve payment of the services. This includes release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medial history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claim for benefits.
- If you have dental insurance, your estimated portion of the charges (deductible or co-pay) is expected at the time of service.
- We ask that you notify the office if your insurance has changed.
- Since we are not a party to the agreement between you and your insurance company, we may ask that you assist us in contacting them in the event that services are not paid within 30 days.
- Insurance claims unpaid after 30 days are the responsibility of the patient.
- If we receive payment from the insurance company and you have already made payment for that date of service, we will prepare a refund for any overpayment and send it to you.

SELF PAY:

- If you do not have dental insurance and you are a "self-pay" patient, we ask that you pay the entire balance at the time of treatment, unless Payment Plan arrangements are made with your doctor and the *Finance Manager*.
- We accept cash, check, and major credit cards, such as *Visa, MasterCard, Discover,* and *American Express*.
- We also have a flexible payment plan called *CareCredit,* which allows you to start treatment today and spread payments over time. Both plans consist of an Interest Free Option and a low interest Extended Payment Plan Option, when you need more time to pay. Applying for approval only takes a few minutes and there is no fee to apply. Our financial coordinator can assist you in setting up a payment plan with *CareCredit* prior to your appointment.
- We participate in a program known as *Vistas* that can draft monthly payments from your checking account or enter charges on your credit card to save you the hassle of remembering to send a payment. This plan requires doctor approval, a credit check, 50% down payment, interest, statement fees, and the payments set to draft monthly from your checking account.

DISCOUNTS:

- If the account balance is zero prior to entering this date's services:
  - A 10% discount will be given when paying the full balance with cash or check.
  - A 5 % discount will be given when paying the full balance with credit card.
- *CareCredit* payment plans do not qualify for discounts.
- ***NEW - We offer membership in a discount plan through Danville Dental that includes $55 check-ups and 10% - 20% off all other dental work. Ask a receptionist for details.***

RETURNED CHECKS:

- There is a $25.00 service charge on all returned checks.

MISSED OR CANCELLED APPOINTMENTS & LATE ARRIVALS:

- Missed appointments, cancellations and late arrivals are a tremendous loss for a practice. Please help our office reduce those losses by canceling with at least 24 hours notice if you cannot keep your appointment.
- Failure to give notice 24 hours prior to your appointment may result in a $50 fee to be paid by the patient or the account being locked for up to 120 days.
- Late arrivals of more than 5-10 minutes may result in rescheduling the appointment to another day.

DELINQUENT ACCOUNTS:

- Financial arrangements and regular payments must be made for balances carried on account by our office. Allowing an account to become seriously past due will result in being turned over to a credit bureau, collection agency and/or the court system. The responsible party will also be required to pay all fees associated with this type of action.

PATIENT INFORMATION:

- Patients are asked to provide Collinsville Dental Associates with current information (including name, address, phone, medical/health and employer changes, etc.) for themselves, their family members and their insurance company and to keep all changes up to date.

By signing below, I acknowledge that payment is due at the time of treatment, unless prior arrangements have been made with the Doctor and Finance Manager before the appointment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. If I am insured, I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____ _____

Signature of Patient or Responsible Party | Printed Name of Patient or Responsible Party | Date

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss you medical and payment information with you family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

You may communicate with the following individuals relating to my medical or payment information:

		Type of Information Allowed to Disclose (Check one or both)		Method of Disclosure (Check one or both)	
Name	**Relationship**	**Medical**	**Billing**	**By Phone**	**In Person**

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I been offered a copy of the HIPAA Consent form.

_____

Patient or Personal Representative Signature (If patient is Minor) Date