Edisto Dental Associates, LLC
Eaglesoft Medical History

Patient Name: _____ Birth Date: _____ Date Created: _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is 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 can receive. Thank you for answering the following questions.

Are you under a physician's care now?	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	If Yes:
Do you use tobacco?	Yes	No	If Yes:

Women: Are you…
[ ] Pregnant/Trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptive?

Are you allergic to any of the following?

[ ] Aspirin	[ ] Penicillin	[ ] Codeine	[ ] Acrylic
[ ] Metal	[ ] Latex	[ ] Sulfa Drugs	[ ] Local Anesthetics

Other?	[ ] Yes	[ ] No	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	Scarlet Fever	[ ] Yes	[ ] No
Arthritis/Gout	[ ] Yes	[ ] No	Epilepsy or Seizures	[ ] Yes	[ ] No	High Cholesterol	[ ] Yes	[ ] No	Shingles	[ ] Yes	[ ] No
Artificial Heart Valve	[ ] Yes	[ ] No	Excessive Bleeding	[ ] Yes	[ ] No	Hives or Rash	[ ] Yes	[ ] No	Sickle Cell Disease	[ ] Yes	[ ] No
Artificial Joint	[ ] Yes	[ ] No	Excessive Thirst	[ ] Yes	[ ] No	Hypoglycemia	[ ] Yes	[ ] No	Sinus Trouble	[ ] Yes	[ ] No
Asthma	[ ] Yes	[ ] No	Fainting Spells/Dizziness	[ ] Yes	[ ] No	Irregular Heartbeat	[ ] Yes	[ ] No	Spina Bifida	[ ] Yes	[ ] No
Blood Disease	[ ] Yes	[ ] No	Frequent Cough	[ ] Yes	[ ] No	Kidney Problems	[ ] Yes	[ ] No	Stomach/Intestinal Disease	[ ] Yes	[ ] No
Blood Transfusion	[ ] Yes	[ ] No	Frequent Diarrhea	[ ] Yes	[ ] No	Leukemia	[ ] Yes	[ ] No	Stroke	[ ] Yes	[ ] No
Breathing Problems	[ ] Yes	[ ] No	Frequent Headache	[ ] Yes	[ ] No	Liver Disease	[ ] Yes	[ ] No	Swelling of Limbs	[ ] Yes	[ ] No
Bruise Easily	[ ] Yes	[ ] No	Genital Herpes	[ ] Yes	[ ] No	Low Blood Pressure	[ ] Yes	[ ] No	Thyroid Disease	[ ] Yes	[ ] No
Cancer	[ ] Yes	[ ] No	Glaucoma	[ ] Yes	[ ] No	Lung Disease	[ ] Yes	[ ] No	Tonsillitis	[ ] Yes	[ ] No
Chemotherapy	[ ] Yes	[ ] No	Hay Fever	[ ] Yes	[ ] No	Mitral Valve Prolapse	[ ] Yes	[ ] No	Tuberculosis	[ ] Yes	[ ] No
Chest Pains	[ ] Yes	[ ] No	Heart Attack/Failure	[ ] Yes	[ ] No	Osteoporosis	[ ] Yes	[ ] No	Tumors or Growths	[ ] Yes	[ ] No
Cold Sores/ Fever Blisters	[ ] Yes	[ ] No	Heart Murmur	[ ] Yes	[ ] No	Pain in Jaw Joints	[ ] Yes	[ ] No	Ulcers	[ ] Yes	[ ] No
Congenital Heart Disorder	[ ] Yes	[ ] No	Heart Pacemaker	[ ] Yes	[ ] No	Parathyroid Disease	[ ] Yes	[ ] No	Venereal Disease	[ ] Yes	[ ] No
Convulsions	[ ] Yes	[ ] No	Heart Trouble/Disease	[ ] Yes	[ ] No	Psychiatric Care	[ ] Yes	[ ] No	Yellow Jaundice	[ ] Yes	[ ] No

Have you ever had a 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: _____

Edisto Dental Associates, LLC
Patient Appointment Agreement

The staff at Edisto Dental Associates is committed to providing our patients with the best care possible. Your clear understanding of our appointment agreement is important to the success of our relationship with you. We are happy to discuss this agreement with you at any time.

Keeping Scheduled Appointments

You may be surprised to know that missed appointments and last minute cancellations are the biggest problems in dental offices. So that we can provide you and your family with their needed treatment, we ask the following from you:

You make every effort to schedule your appointments for a time that you can keep. We require a minimum of 24 hours notice if you must cancel an appointment. There will be a missed appointment fee of $25 charged to your account if not cancelled within the required time frame or if you do not show up for your scheduled appointment. Because missed appointments send the message that your scheduled appointment and our reserved time are not important, we will discharge your family from our practice should this become a pattern. We will attempt to remind you with a reminder call of your appointment one or two days prior to your appointment, please make sure your contact numbers are updated in our files.

Medicaid Coverage Responsibilities:

- Please bring the Medicaid card to your appointments
- Please notify us if your Medicaid eligibility changes, especially if you have an appointment scheduled. Your notification will allow us to verify coverage so your appointment can proceed as scheduled.

With your support and cooperation, we look forward to taking care of your smile!

Your signature below indicates acceptance of Edisto Dental's Patient Appointment Agreement.

Print Name: _____ Date: _____

Patient or Responsible Party Signature: _____

Acknowledge of Receipt

I acknowledge that I received a copy of Edisto Dental Associates Notice of Privacy Practices.

Name: _____ Date: _____

Patient Authorization for Release of Protected Health/Dental Information to Another Person

(Spouse, Friend, Family)

By signing I authorize Edisto Dental Associates to release verbal information, or copies of protected health/dental information about me to:

List Person(s) Below:

_____

_____

_____

_____

_____

This authorization permits Edisto Dental Associates to release the following individually identifiable health/dental information about me such as the following: (Medical Notes, Labs, or Any Accounting Information to the Person(s) Above).

The information will be used or disclosed for the following purpose: For Continued Medical Release of the information.

The purpose(s) is/are provided so that I can make an informed decision on whether to allow release of the information.

My Patient Rights Are:

I do not have to sign this authorization in order to receive treatment from Edisto Dental Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the HIPPA Privacy Law. I have the right to revoke this authorization in writing except to the extent that the submitted to the privacy officer.

Signed by: _____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

RELATIONSHIP TO PATIENT

Edisto Dental Associates, LLC
Patient Financial Policy

Patient Name: _____ **Date of Birth:** _____

Thank you for choosing **Edisto Dental Associates** as your Dental/Health care provider. We are committed to providing you with the best treatment available. We will bill your insurance as a courtesy to you with a copy of your current insurance card. If we do not have your insurance card, full payment is due at the time of service. We accept **Cash, Check, Master Card, and Visa.** There will be a $30 charge for returned checks. If payment is not received from your dental insurance carrier within our contract limits, any balance will be your responsibility. Our billing/insurance department is available to discuss any questions you may have regarding your insurance or account at **Edisto Dental Associates.**

Medicaid: We accept Medicaid for patients 21 and under. If there is a dental service not covered by Medicaid, you will be asked to sign a waiver and you will be responsible for the charges in full at the time of service.

PPO/Commericial/Medicaid: All co-pays are due at the time of service, we are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. You are responsible for referrals, payments of all deductibles and co-payments/co-insurance, procedures without authorization, non-covered charges as determined by your contract with your dental insurance carrier. All payments are due at the time of services.

Unusual and Customary Rate: We are committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your dental insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Self-Pay: If you do not have health insurance you will be responsible for all medical services rendered at **Edisto Dental Associates**. Payment in full is due at the time of service. If you are unable to make full payments, suitable payment arrangements will be discussed between you and our financial counselors.

Delinquent Accounts: If your account becomes delinquent, **Edisto Dental Associates**, will take the necessary steps to collect the debt, including but not limited to collection agency, lawyer, and reporting to a Credit Bureau where you agree to pay all the collection costs incurred.

I have read, understand, and agree to abide by its guidelines the payment policy regarding my financial responsibility to **Edisto Dental Associates**. For providing medical services to me or the above named patient. I certify that the information I provide to **Edisto Dental Associates** is, to the best of my knowledge, current, true, and accurate.

Patient Signature: _____ **Date:** _____

Guarantor Signature: _____ **Date:** _____
(If guarantor is not patient)

Edisto Dental Associates, LLC
Eaglesoft Medical History

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. 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.

Payment for all treatment and services rendered are my responsibility and are rendered at time of appointment unless prior agreements have been made with the appropriate Edisto Dental Associate.

_____ _____
PATIENT SIGNATURE DATE

Sign here if patient is a child or requires a guardian:

_____ _____
PARENT/GUARDIAN SIGNATURE DATE