ARRINGTON
DENTAL

1. Patients name_____ Cell Phone _____
   Spouses name _____ Email _____
2. Home Address _____ Home Phone _____
3. City _____ State _____ Zip _____
4. Birth date _____ Social Security # _____
5. Employer _____ Work Phone _____
6. If a minor, parents first and last names _____
7. Person responsible for account (if other than patient)
   Name _____Relationship _____
   Birth date _____ Social Security # _____
   Employer _____ Work Phone _____
8. Name of nearest relative not living with you _____
   Relationship _____Address _____ Phone _____
9. Dental Insurance

_____	_____	_____	_____
Insurance	Employer	Group #	SS#

10. I hereby authorize payment directly to Arrington Dental
    Signed (insured person) _____Date _____
11. Reason for visit _____
12. Name of previous dentist _____
13. Frequency of previous dental care _____
14. Date of last dental visit _____

Whom may we thank for referring you to our office? _____

Time 1:50 PM

Arrington Dental

Date 9/21/2021

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, 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

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:_____

FEE PAYMENT AND INSURANCE INFORMATION

PATIENT NAME: _____

In an effort to inform you and to avoid misunderstandings, we feel that it is appropriate to outline our office policy on payments for professional services. Each patient is responsible for his/her account and payment is expected in full when services are rendered. For your convenience, we accept cash, checks, Via, MasterCard, and Discover. We also offer the option of an interest-free payment plan available for qualified patients through an outside lending institute. Patients interested in the payment plan must fill out an application for approval and should request information and an application from the financial manager prior to treatment.

As a courtesy to our patients, we are happy to help you process your Insurance. We will complete our portion of the claim form and submit the claim promptly, at no charge. Insurance coverage is usually limited to a portion of the fee agreed upon by you in our office. There categorically is no such thing as a "UCR" (usual and customary) fee for nation state or zip code that is not created internally by the Insurance company. The Insurance companies are solely responsible for those numbers.

It will be your responsibility to check with your Insurance company, prior to treatment; to be sure there are no waiting periods, exclusions, or limitations for any of the treatment we have recommended. Regardless of what we may calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the TOTAL cost of your dental treatment.

As a courtesy to you we will bill your Insurance carrier for you and accept assignment of your benefits. Once the carrier is billed, we will set aside that portion of your balance, estimated to be paid by your insurance carrier within thirty (30) days.

We require that your estimated share be paid at the time services are rendered. Our fees are not determined in cooperation with Insurance companies and therefore some of the reimbursements may not cover the amount stated in your Insurance policy. If your Insurance carrier does not remit payment within sixty (60) days, the balance will be due, in full, from you. If, at a later date, any payment is subsequently made by your Insurance carrier in excess of the balance we estimated, we will promptly refund the correct amount.

We are not In-Network with any Insurance plan, members of any groups, nor do we agree to any fee schedules other than those agreed upon between the patient and this office. When you receive treatment in this office, you agree to be financially responsible for the entire fee, independent of Insurance coverage.

If you have any questions, regarding fees, filing of Insurance, or payment options, please seek assistance from our financial manager prior to treatment.

IN ORDER FOR US TO PROCESS YOUR PAPERWORK AS QUICKLY AS POSSIBLE, WE ASK THAT YOU CHECK THE METHOD OF PAYMENT WHICH YOU WILL BE USING TODAY:

_____Insurance _____Cash/Personal Check _____Credit Card _____Care Credit

_____

Patient or responsible party: I have read all of the above information and agree to abide by its content.

_____

Patient or responsible party: authorize payment of Insurance benefits directly to the provider.

_____

Patient or responsible party: I authorize the release of all necessary information to the Insurance carrier and their representatives.

ARRINGTON
DENTAL

Patient Name: _____ Date of Birth: _____

I have received and reviewed a copy of Arrington Dentals privacy, security and breach notification policies and procedures.

I agree that Arrington Dental may communicate with me electronically at the email address below. **I am aware that there is some level of risk that third parties might be able to read unencrypted emails.** I am responsible for providing Arrington Dental with any updates to my email address. I can withdraw my consent to electronic communications by calling: 806-665-0037

Email Address (PLEASE PRINT CLEARLY):

_____

Patient Signature: _____

Date: _____