MAIN STREET DENTAL

First Name: _____Middle Initial: _____ Last Name: _____

Date of Birth: _____Email: _____

Social Security #:_____ Home Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____State:_____Zip:_____

Employer: _____ Work Phone #:_____

Referred By:_____

Preferred Pharmacy: _____ Phone #: _____

Spouse / Person Responsible for Account if Other than Patient

Name: _____ Relationship to Patient: _____ Phone #: _____

Date of Birth: _____Social Security: _____ Employer:_____

Address: _____ City: _____ State:_____ Zip:_____

Insurance Information

Primary Insurance Company:_____ Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's ID #:_____ Group #:_____

Insurance Company Address: _____ City:_____ State: _____ Zip:_____

Insurance Company Phone:_____ Insurance Company Fax:_____

Secondary Insurance Company:_____ Policy Holder:_____

Policy Holder's Date of Birth: _____ Policy Holder's ID #:_____ Group #:_____

Insurance Company Address: _____ City:_____ State: _____ Zip:_____

Insurance Company Phone:_____ Insurance Company Fax:_____

PAYMENT IS DUE AT TIME OF SERVICE

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	

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

Do you use controlled substances?	Yes No	If yes
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	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:_____

MAIN STREET DENTAL

Smile Assessment Form

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental team will discuss your response with you in confidence.

1. I am concerned about the general apperance of my teeth or my smile. YES NO

2. I am concerned about the level of whiteness if one or more of my teeth. YES NO

3. I am concerned about the position or alignment of one or more of my teeth. YES NO

4. I am concerned about the shape of one or more of my teeth. YES NO

5. In social situations, I am somewhat embarrassed by my teeth or my smile. YES NO

6. There are some things about my upper front teeth that I would like to change. YES NO

7. There are some things about my lower front teeth that I would like to change. YES NO

8. I have old fillings or previous dental work that is no longer or has never been satisfactory to me. YES NO

9. I am missing one or more of my front/ back teeth. YES NO

10. I am interested in learning more about esthetic dentistry. YES NO

Please use the space below to indicate any other problems, concerns or questions. We will listen attentively to your concerns so that we can present you with the best possible treatment options.

Thank you!

Dr. Teresa Ruehl, D.D.S.
Main Street Dental
850 Main Street
Lander, Wy 82520
(307) 332-2201

MAIN STREET DENTAL

Financial Agreement

Payment for services is due at the time services are rendered

We accept cash, check, and all major credit cards.

The parent/family member is responsible for treatments and payments the day of service. Some appointments will require a $100.00 deposit. There is a return check fee of $30.00.

Insurance and Third Party Payments

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, but we will process claims for you and do all we can to get them paid. Please be aware that some, and perhaps all, of the services provided may be non-covered or may not be considered usual and customary under your insurance plan. While we try to estimate insurance payments, it is your responsibility to be aware of your benefits. You are responsible for the balance regardless of any insurance company's arbitrary determination of usual and customary rates or non-covered services.

Complete insurance information must be presented at the time services are provided. Most benefits will be verified before your insurance company can be billed. While we try to verify benefits and estimate insurance payments, it is ultimately your responsibility to be aware of your benefits. Your estimated portion after insurance payment must be paid at the time of service.

By signing this financial agreement, you understand that payment is expected at the time of service. If you do not pay in a timely manner you may be sent to a collection agency or small claims court and will incur reasonable court costs or attorney fees, with or without suit. These fees will be added to your bill should any collection actions need to be taken. In the event this agreement is assigned to a collection agency, an additional collection fee of 35% of the unpaid balance will be added to the balance due.

If you cannot keep the appointment time specifically reserved for you, we ask that you give our office two (2) business days notice. Some appointments require a $100.00 deposit to hold your appointment time; if you cancel the appointment with less than two (2) business days notice you may forfeit the deposit. Changes to appointment are not accepted on the answering machine. Without this notice, your account will be assessed a $34 no-show fee which is due before you can be seen again. Patients who habitually fail appointments may be dismissed from the practice.

Insurance Verifications and Billing

I authorize Main Street Dental to contact my insurance carrier in order to determine eligibility for medical services performed in the dental office. I understand that my insurance will be billed for services rendered by Main Street Dental. I agree that if my insurance carrier issues a check in my name for reimbursement for services performed by Main Street Dental, I am responsible for payment to Main Street Dental. I agree that Main Street Dental may receive payment directly from my insurance carrier.

I have read, understand, and agree to this Financial agreement.

Patient Signature_____ Date_____

Please Print Name _____

MAIN STREET DENTAL

I understand that, under the Health Insurance Portability & Accountability Act of 1995 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatments and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

* Obtain payment from third-party payers

* Conduct normal healthcare operations such as quality assessments and physician certifications

I have the right to read the Notice of Privacy Practices before deciding whether to sign this consent.

This office reserves the right to change the privacy practices as described in the Notice of Privacy Practices. If it is changed, a revised Notice of Privacy Practices will be issued.
I have the right to request that you place additional restrictions to use or disclosure of my health information. You are not required to agree to these additional restrictions, but if you do, you will abide by our agreement (except in an emergency).
I understand that I may revoke this consent in writing at any time , except to the extent that you have taken action relying on this consent.

Signature_____ Date _____

Authorization for Release of Information to Family Members

If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Main Street Dental to release my medical and/ or billing information to the following individual(s):

1._____ Relation to Patient_____

2._____ Relation to Patient_____

3._____ Relation to Patient_____

I understand I have the right to revoke this authorization in writing at any time and that I have the right to inspect or copy the protected health information to be disclosed.

Signature_____ Date _____