2021

AUSTIN/PRAY FAMILY DENTISTRY

218-A East Shockley Ferry Rd. Anderson, SC 29624 (864)226-4411

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, **please fill out this form completely in ink.** If you have any questions, please ask us and we will be happy to help. **Please arrive 15 minutes prior to your appointment time** to allow us to verify insurance or to fill out any other paperwork.

Today's Date_____

Personal Information

Birth date_____ Soc. Sec. # _____

Name _____Wishes to be called _____M/F (Please Circle)

Address_____

_____

Home Phone _____ Cell Phone_____

Work Phone _____Email_____

May we contact you by email? Yes/No May we contact you by text message? Yes/No

Employer _____Occupation_____

Do you have new Insurance? Yes/No ** **If yes please give card to front desk staff to make a copy**

Referred by_____

In the event of an emergency, who should we contact? Name_____

Relationship _____Phone #_____

Responsible Party

Are you the responsible party for this account? Yes/No (If no, please complete below)

Name _____Relationship to patient_____

Birthday _____Soc. Sec.#_____

Address_____

City, State, Zip_____

Home Phone _____Cell Phone_____

Employer _____Work Phone_____

Written Financial Policy

Thank you for choosing our office. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy as manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, Master Card or American Express

-NO INTEREST Payment Plans from CareCredit®

- Allows you to pay overtime with NO INTEREST
- Convenient, low monthly payment plans also available
- No annual fees or pre-payment penalties

Please Note:

_____This office will be happy to work with your Insurance carrier to maximize your benefits, and directly bill them for reimbursement on your behalf as a **courtesy** to you. **HOWEVER, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier**. Any request from your insurance company only delays payments. A charge of $18.00 will be added to re-file any insurance claims.

We offer a 5 to 10% courtesy for Senior Citizens (62 years old and up) who pay in full prior to completion of care. This courtesy is only offered for seniors with no dental insurance.

_____ Broken appointment fees of $35.00 up to $50.00 (depending on appointment type) will be charged for patients who miss or cancel without at least a 24-hour notice.

_____We will charge a fee of $35.00, for all returned checks.

_____**I authorize and request my insurance company to pay directly to the dentist.**

_____By checking this box, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

Call me____ Text me____ Call me and text me____

_____ Permission for Treatment and Promise of Payment

This is to certify that I, the undersigned, consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs. I also accept responsibility for any service charges on past due accounts, associate charges for broken appointments, and all reasonable attorney fees incurred in the collection of those fees.

_____

Patient, Parent of Guardian Signature Date

_____

Patient Name (Please Print)

Eaglesoft Medical History(Copy)

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	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
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	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ 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
Low Blood Pressure	◯ 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
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ 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:_____