2017 Information Update

PLEASE PROVIDE US WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE, SO WE CAN MAKE A COPY FOR OUR RECORDS.

Patient Name: _____ **Today's Date: _____**

Date of Birth: _____ **Email Address**: _____@_____

Social Security#:_____ **Do you receive emails?** Yes or No

Cell#:_____ **Do you receive text?** Yes or No

Home #:_____ **What is the best way to confirm your appointment?**

Work#_____EXT._____ Phone Call Text Message Email

Mailing Address _____

City _____ **State** _____ **Zip** _____

Emergency Contact Information: (Parent or legal guardian information if the patient is under 18)

Person to contact in case of an emergency:_____

Relationship to patient:_____ **Phone #**_____

Responsible Party Information:

Who is responsible for this account? _____ **Relationship to Patient?** _____

Responsible Party's Date of Birth _____ **SS #** _____

Place of Employment _____ **Work Phone Number** _____
Alternate Number _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **ID#**: _____

PATIENT IS RESPONSIBLE FOR OBTAINING ALL REFERRALS

I HEREBY AUTHORIZE ASSIGNMENT OF BENEFITS TO BE PAID DIRECTLY TO DOCTOR TULLOS OF TULLOS FAMILY DENTISTRY. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTILL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICE WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL FOR ALL COINSURANCE AND DEDUCTIBLE COSTS, AS WELL AS ANY DOCTOR'S SERVICES WHICH ARE DETERMINED TO BE NON-COVERED OR DENIED. I AUTHORIZE MY PHYSICIAN TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY BILL. WE RESERVE THE RIGHT TO ADD A FINANCE CHARGE TO ANY PAST DUE ACCOUNT.

PATIENT/GUARDIAN SIGNATURE: _____

NEWEaglesoft Medical History(Copy)-Updated2

Patient Name: Birth Date: Date Created:

How long ago was your last dental visit?

☐ 6 months ☐ 1 year ☐ 5 years ☐ More than 10 years
☐ Never ☐ Other_____

Do you have a former Dentist? ◯ Yes ◯ No If yes

Do you have a family doctor? If yes, Please list your doctor's name. ◯ Yes ◯ No If yes

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

Please list all medications you are currently taking.

Please list your current Pharmacy, phone number, and location:|

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 have any allergies other than what is listed above? ◯ Yes ◯ No If yes

Have you ever used crystal meth? ◯ Yes ◯ No If yes

Do you use any type of tobacco?

☐ Cigarettes ☐ Smokeless Tobacco ☐ Cigars

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

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:_____

Tullos Family Dentistry, P.A.
276 Magnolia Drive
Raleigh, MS 39153
601-782-9909

SECTION A: Acknowledgement of Receipt of Privacy Practice Notice.
I, patient/patient's guardian _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

SECTION B: Appointment & Scheduling Guidelines.
If you find that you must change your appointment, we require a minimum of 24 hours' notice so that we may accommodate another patient. A charge will be applied for broken and missed appointments without advanced notification.

SECTION C: Financial Agreement
Payment is expected in full at the time services are rendered. If you have insurance…we will gladly process your claim, but we request that you pay your estimated portion in full when services are rendered. We offer several methods of payments including Cash, Check, Credit Card, and Care Credit. If your account becomes past due and collection procedures are rendered, you will be responsible for ANY and ALL cost. WE RESERVE THE RIGHT TO ADD A FINANCE CHARGE TO ANY PAST DUE ACCOUNT.

SECTION D: Social Media Release
I hereby grant permission to Tullos Family Dentistry to use my photo or other material to Tullos Family Dentistry's web site, Facebook account, or other entity. I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said materials, including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights. I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the materials or any rights therein.

Signature: _____ Date: _____