

## 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: \_\_\_\_\_

\*\*\*NEW\*\*\*Eaglesoft 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 <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problems <input type="radio"/> Yes <input type="radio"/> No        | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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: \_\_\_\_\_