Patient Information

First Name: ____________ Last Name: ____________ Preferred Name: ____________

Mailing Address: ____

Birthdate: ____________ Gender: o F o M SSN: ____________ Marital Status: ____________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ Email: ____________________

Employer: ____________________ Occupation: ____________________

How did you hear about Zöe Dental? ____________________________________

Emergency Contact Name: ____________________ Relationship: ____________________

Cell Phone: ____________________ Work Phone: ____________________

Responsible Party Information (please complete if different from above)

First Name: ____________ Last Name: ____________ Preferred Name: ____________

Mailing Address: ____

Birthdate: ____________ Gender: o F o M SSN: ____________________

Home Phone: ____________________ Cell Phone: ____________________

Relationship to Patient: ____________________ Is this person also a policy holder? o Yes o No

Insurance Information

Policy Holder Name: ____________________ Policy Holder SSN: ____________________

Policy Holder's Employer: ____________________ Policy Holder's DOB: ____________________

Insurance Company: ____________________ Policy Holder's Relationship to Patient: ____________

At Zöe Dental, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us. We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and, therefore, have more time to dedicate to your dental care. If you have any questions regarding the following information, please do not hesitate to ask… we are here to help!

By initialing each section, you indicate you have read the policies as described in this form. You agree to abide by the terms outlined.

FINANCIAL RESPONSIBILITY: I will be financially responsible for any and all charges for services rendered at Zöe Dental, regardless of insurance coverage. It is my responsibility, and not the responsibility of Zöe Dental, to know if my insurance will cover dental services. It is my responsibility to know if my insurance has any deductibles, maximums, or other benefit limitations. It is my responsibility to know if the provider I am seeing is a contacted in-network provider recognized by my insurance company. Initial: ________

INSURANCE INFORMATION: As a courtesy to you, Zöe Dental submits claims to your dental plan free of charge. Please keep in mind that as dental care providers, our relationship is with you, the patient, not the insurance company. We ask that you realize that we do not work for an insurance company. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage. We must emphasize that the dental insurance contract is an agreement between you and your insurance company; therefore, you will be responsible for the bill, regardless of insurance coverage. We cannot render services based on the assumption that the charges will be paid for by the insurance company. All charges are your responsibility from the date the services are rendered. Be familiar with the benefits and limitations on your dental plan(s). I understand and accept my financial responsibilities. I authorize release of information necessary to process my dental insurance claims. I also authorize payment directly to Zöe Dental for insurance benefits otherwise payable to me.

Initial: __________

COLLECTIONS: Zöe Dental partners with Professional Recovery Consultants (PRC) for overdue accounts. Accounts will be turned over to PRC if a bill has not been paid within 90 days from the date of service and no payment arrangements have been made with Zöe Dental financial department. I agree in order for Zöe Dental and PRC to be able to service my account or collect any amounts I may owe, that I may be contacted by telephone at any telephone number associated with my account, including wireless numbers, which could result in charges from my wireless carrier. Methods of contact may include recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. Initial: _________

APPOINTMENT CHANGE POLICY: We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your scheduled appointment is reserved exclusively for you. Zöe Dental has a 48-hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a 48-hour notice is given. If sufficient notice is not given, your account will automatically be charged a $40 missed appointment fee. We ask that you make every effort to keep your reserved time. Initial: __________

APPOINTMENT DEPOSIT POLICY: Our doctors require a 10% deposit for any *treatment* scheduled. This deposit will go towards your patient financial responsibility and is transferrable if sufficient 48-business hours' notice is given. The 10% deposit is due upon scheduling your treatment appointment.

Initial: __________

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I certify that I have been offered and read a copy of the HIPAA Notice of Privacy Practices. I hereby authorize Zöe Dental to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. Initial: __________

AUTHORIZATION TO MAIL, CALL, TEXT, OR EMAIL: I certify that I understand the privacy risks of mail, phone calls, texts, or emails. I hereby authorize the staff of Zöe Dental to mail, call, text, or email me in regard to my healthcare, including but not limited to, appointment reminders, referral arrangements, and account information. I understand that I have the right to rescind this authorization at any time by notifying Zöe Dental of this change in writing. Initial: __________

HIPAA INFORMATION RELEASE: In order to protect your patient confidentiality, we need to know if there is a phone number (with voicemail) for you where we leave results of dental treatment, or other sensitive information. By indicating the information below, I give Zöe Dental staff permission to leave confidential health care information for me at the following number(s):

Phone number: __________________ home / work / cell (please circle one) Phone number: __________________ home / work / cell (please circle one)

O I do NOT wish to have any of my information recorded on my personal voicemail.

I hereby authorize one or all of the parties below to request and receive any protected health information verbally or in a voicemail message as designated below. I understand that the identities of each designated party must be verified before the release of any information.

O I do NOT wish to have any of my information released to someone other than myself.

Name: ____________________________ Relationship: ____________________________ Phone: ____________________________

May speak with them in regard to: o Appointments o Treatment o Payment/Billing

Time 11:57 AM | Zöe Dental | Date 9/18/2018

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

Question	Answer	
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?

Condition		Condition		Condition		Condition	
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:__________