Patient Information

First Name: ____________ Middle Initial: ______ Last Name: ____________

Address: ____________ City: ____________ State: ______ Zip: ________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Sex: ○ Male ○ Female Employment Status: ○ Full Time ○ Part Time ○ Retired

Birth Date: ____________ Soc Sec: ____________ Email: ____________

Marital Status (Circle One): Married Single Divorced Separated Widowed

Referred by: ____________ Previous Dentist: ____________

Responsible Party (If someone other than the patient fill out)

First Name: ____________ Middle Initial: ______ Last Name : ____________

Address: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Birth Date: ____________ Soc Sec: ____________ Email: ____________

Primary Insurance Information

Name of Insured: ____________

Insured Birth Date: ____________

Insured Soc. Sec: ____________

Employer: ____________

Relationship to Insured: ____________

Ins Company: ____________

Secondary Insurance Information

Name of Insured: ____________

Insured Birth Date: ____________

Insured Soc. Sec: ____________

Employer: ____________

Relationship to Insured: ____________

Ins Company: ____________

Individuals that we are authorized to Speak to About your Care

Emergency Contact: ____________ Phone: ____________ Relationship: ____________

Signature: ____________ Date: ____________

Time 2:17 PM

Date 10/18/2018

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	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
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	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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:

PCP:
Height:
Weight:

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:

Office Policy

Office policies and fees for services provided are determined by Dr. Sam Barnhart only. Insurance companies make their own decisions on which procedures and how much they will pay for each. The doctor has no control or participation with any insurance company or policy except Delta Dental Premier. We will file your dental insurance for you. It is your responsibility to make sure they pay on your claim. Dr. Sam provides insurance companies with pre-operative x-rays, photos, and in some cases written narratives, to help ensure proper coverage by your insurance, but if for some reason your insurance company denies your claim, you are fully responsible for any remaining balance you may have accrued above and beyond your expected co-pay that you have already paid. You are financially responsible for any difference in billed amount and payment from insurance. In the event that your insurance checks are inadvertently sent to you, you may pay the office directly for the insurance payments you received. **Payment and or Insurance Co-payments are due prior to scheduling any treatment visits**, to include the office visit and the anticipation out-of-pocket cost for your specified procedure. Methods of payment include cash, credit card or check. In the event that your insurance company does not pay for any reason you are responsible for the bill in full. It is your job as a patient to know and understand your insurance plan policies.

Cancellation Policy

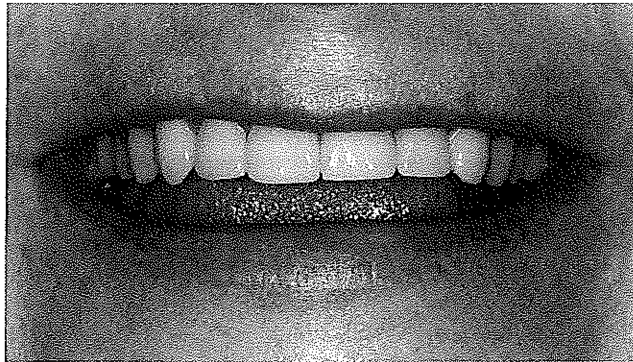
We understand emergencies do occur and it may be impossible for you to make all appointments. However, we do expect to be notified within **48 hours** in advance if you will not be able to make a scheduled appointment. In the event that you miss your appointment without notifying us in advance, a note will be made in your chart. Once you miss two appointments without prior notification, we reserve the right to discontinue your appointments. We ask that you respect our time, and we will respect yours.

In-Office Photography

Pyramids Dental uses patient intra-oral (inside the mouth) photos to help patients understand their treatment needs and highlight the changes that have been made to their smile. These photos are also used to show other patients, in the office, of what their potential outcomes could be. We also take professional-grade extra-oral (outside the mouth) photos of patient's smiles, full face, and dental restoration photos that we will use on our **website** to show before and after of dental work, and **'Dental Transformations'**. Our practice is built around happy, healthy smiles and we want to show these transformations off! Close up shots of teeth only are used for in-house and Pyramids Dental promotional items within the office. For example; before and after photos shown chairside to new patients, photos

used on TV in waiting room, photos used on the monitors in the operatories, or images within our services section on the website.

As the owner of Pyramids Dental, I ask for your consent to use the above described photos



Pyramids Dental GUARANTEE!

We want our patients to feel secure in their decisions for treatment. Our "Crowns" or "Caps", as they are commonly called, come with a **Lifetime Guarantee Against Fracture**. If your crown breaks we will fix it at **no charge provided that you keep all recall check-up appointments** after your crown is completed. Your Check-Ups are due every six months—we will see you then!

Thank you for choosing Pyramids Dental as your dental care providers. We look forward to many years of great service and friendship with you and your family.

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Patient/Guardian Signature Date

Financial and Cancellation Policies

- We accept Cash, Checks, Debit Cards, Visa, MasterCard, American Express, Discover, and CareCredit.
  - Financing may be available through Lending Club – ask the front desk for more details.
- All services are to be paid for at time of treatment. Please discuss all payment arrangements with the office manager prior to any treatment performed.
  - For implants, crowns, bridges, oral appliances, or prosthetics:
    - a non-refundable 50% deposit will be required before your case is sent to the lab
- Dental insurance coverage is a contract between you and your insurance company. Therefore, you are still ultimately financially responsible for your dental services.
  - If we are not participating providers of your insurance plan, as a courtesy, we will be happy to submit a claim to your insurance carrier and payment may be made directly to you from your insurance provider.
  - The patient is responsible for payment, in full, regardless of dental insurance coverage, divorce, or any other financial arrangements made between the patient and others.
  - It is your responsibility to present any insurance information PRIOR to treatment.
- Invoices for any unpaid amount will be sent from this office once per month. Your signature below attests that you are aware that if you do not respond after three attempts to collect a balance, we may send your delinquent bill to a collection agency.

POLICY FOR BROKEN AND/OR CANCELLED APPOINTMENTS

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Free consultations may expect an extended wait time, as we try to take care of our existing patients' appointments in a timely manner, while working in free consultations throughout the day.

We hope you will make every effort to keep your appointments. Kindly give 48-hour notice for cancellations to avoid loss of deposit. It must be understood that once you miss an appointment without giving 48-hour notice, we may require a deposit from you for all future appointments. If you have any questions, please do not hesitate to ask. Thank you for understanding our policies.

Your signature verifies that you have read the above stated policies, have had the opportunity to have all your questions addressed, and agree to the terms listed above.

SIGNATURE – PATIENT/GUARDIAN	DATE