



First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient is: ☐ Responsible Party ☐ Policy Holder

PATIENT INFORMATION:

Address: _____ Address 2: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth date: _____ Employer: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed

Student Status: ☐ Full Time ☐ Part Time Name of School: _____

E-mail: _____ ☐ I would like to receive email confirmations

How did you first find us? ☐ Insurance Website ☐ Walk-in/Drive by ☐ Facebook ☐ Yelp ☐ Google Search
☐ Milestone Website ☐ Referred by someone ☐ Other: _____

What did you use to find out more about us? ☐ Milestone Website ☐ Facebook ☐ Yelp ☐ Google Search
☐ Other: _____

If referred, whom can we thank? _____

RESPONSIBLE PARTY: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Birth date: _____ Employer: _____

E-mail: _____ ☐ I would like to receive email confirmations

☐ Responsible Party is Policy Holder for Patient ☐ Primary Policy Holder ☐ Secondary Policy Holder

PRIMARY INSURANCE

Name of Subscriber: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Social Security #: _____ Subscriber Birth date: _____

Employer: _____ Subscriber ID: _____

Insurance Company: _____ Insurance Phone #: _____

Group Name _____ Group Number: _____

SECONDARY INSURANCE

Name of Subscriber: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Social Security #: _____ Subscriber Birth date: _____

Employer: _____ Subscriber ID: _____

Insurance Company: _____ Insurance Phone #: _____

Group Name _____ Group Number: _____

Milestone Dental Group
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

| | | | |
|---|--|--------|-------|
| Are you under a physician's care now? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Have you ever been hospitalized or had a major operation? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Have you ever had a serious head or neck injury? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Are you taking any medications, pills, or drugs? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Are you on a special diet? | <input type="radio"/> Yes <input type="radio"/> No | | |
| Do you use tobacco? | <input type="radio"/> Yes <input type="radio"/> No | | |

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 use controlled substances?

☐ Yes ☐ No

If yes

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 _____

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: _____



PEDIATRIC INTAKE FORM

CHILD'S NAME _____

DOB _____

CHILD'S PEDIATRICIAN _____

Phone #: _____

FEEDING

1. Is your child currently breastfeeding? **Y N** If yes, how many times per night does s/he breastfeed? _____

2. Does your child drink from a bottle/sippy cup? **Y N**

3. Does your child drink juice? **Y N** How often? _____

ORAL HABITS

1. Does your child suck their thumb/use a pacifier? **Y N**

2. At what age did your child stop thumb-sucking/pacifier? _____

FLUORIDE EXPOSURE

1. Did/does your child drink baby formula? **Y N** . Was/is it reconstituted with bottled water or tap water? **Y N**

2. Does your child use fluoridated toothpaste? **Y N** If yes, how much? _____

3. Does your child use fluoridated mouth rinse? **Y N** 4. Does your child take a fluoride supplement? **Y N**

5. Does your child drink tap water? **Y N**

ORAL HYGIENE

1. How many times per day does your child brush their teeth? _____ Do you help? _____

2. Does your child floss? **Y N** How often? _____

ORAL INJURY

1. Has your child sustained an injury to their face or teeth? **Y N**

If yes, please explain (when/what happened) _____

2. Does your child play a sport? **Y N** If yes, do they wear a mouth guard? **Y N**

GENERAL

1. Has your child had a previous negative experience at a dental office? **Y N**

If yes, could you tell us more about that (when/what happened) _____

2. How do you think your child will respond to his/her cleaning and exam today? _____

3. What is your child's primary interest (toy, book, game, character)? _____

4. Do you have any specific questions or concerns regarding your child's teeth or oral health? _____

Parent Printed Name

Parent Signature

Date

**DENTAL INSURANCE:**

As a courtesy we will file your insurance claim for you. We offer this service to you as a courtesy only and it is not meant to be a substitute for payment. We will attempt to collect from your insurance carrier their portion of the charges for your visit. We cannot guarantee that they will pay any amount for your treatment. Each plan has different exclusions and limitations and those exclusions and limitations change over time. Our office recommends dental treatment based on medical necessity and not whether your insurance company will cover a procedure. It is your responsibility to know your dental coverage and to pay any amount not covered by your insurance company regardless of the reason. We will instruct your insurance carrier to send all payments directly to our office for reimbursement.

PAYMENTS AT TIME OF SERVICE:

At the time of service, your estimated co-payment is due. For procedures with multiple appointments, at least fifty percent of your estimated portion is due at the first appointment and the balance is due by the beginning of the final appointment.

APPOINTMENT POLICY:

The nature of your dental treatment may require a series of appointments that require resting time to promote healing until next visit. It is imperative that your appointments be maintained in order; otherwise your treatment may be delayed several months.

MISSED/CANCELLED APPOINTMENT CHARGE:

Any appointment that is missed or not cancelled within 2 business days of the appointment will be subject to a charge of \$75.00 for the first occurrence.

Future missed or cancelled appointments may require a deposit prior to rescheduling in addition to the missed/late cancel fee. No further appointments will be made until the fee is paid. Cancellations must be made during business hours. Messages left after 6:00 pm will be considered to have been made on the next business day.

INITIALS

AGREEMENT:

I have read, understood, and agreed to all of the above financial and appointment policies of Milestone Dental Group. I understand that treatment cannot begin until this form is signed and agreed to. I understand that I am responsible for my dental cost regardless of any insurance coverage.

Name

Signature

Date



HIPAA PRIVACY CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 *HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (my insurance company).
- The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are often bound to comply with the restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or requires that we do so. You may see your record or get more information about it by contacting our privacy officer.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize the dentist to perform diagnostic procedures and treatment as necessary for the delivery of proper dental care.

I authorize release of any information concerning my (or my child's) health care, for advice and treatment provided for the purpose of evaluation and administration of claims for insurance benefits.

I authorize the release of any information concerning my (or my child's) health care, for advice and treatment to another dentist, or another health-care professional and their staff.

Name

Signature

Date



DENTAL TREATMENT CONSENT FORM

1. WORK TO BE DONE

I understand that I am having the following work done:

Exam: ☐

X-Rays: ☐

Cleaning: ☐

2. FOR FEMALES ONLY: Are you pregnant or any chance you may be: _____ YES _____ NO

Scientific and medical experts recommend that the exposure to x-rays of an embryo/fetus in a pregnant woman should be minimized in consideration of the developing unborn child. Rapidly developing organs in the unborn child are more sensitive to possible radiation damage than that of a mature adult. While experts generally feel that the risk of damage from diagnostic levels of x-rays are minimal, such exposures are never without risk. Possible undesirable effects may be genetic, i.e., may be passed on to future generations. It is the responsibility of each patient to disclose her possible pregnancy, and with the assistance of her physician, make personal determination as to whether or not to proceed with diagnostic x-rays.

3. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

4. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures

Name

Signature

Date