New Patient Information

Personal Information

Name: _________________________________ Marital Status: __________________

Address: ______________________ City/State/Zip: ____________________________

SSN: _______________________ DOB: ______________________

Driver's License #:_________________________ State: __________________

Home Phone: _____________ Cell: ______________ Email: _____________________

Emergency Contact: _________________________ Phone Number: ______________

How would you like to be contacted for your appointments and other notifications?

By email? Yes/No By Text? Yes/No By Phone call? Yes/No

Employer Information

Employed by: ___________________________ Present Position: _________________

City: ____________________ State/Zip: ____/_______ Work Phone: ______________

Insurance Information

Do you have dental insurance? Yes/No Name of Insurance Company: ______________

Name of person carrying ins. (If different than above): ___________________________

Subscriber's SSN: ___________________________ DOB: ______________________

Employed by: __________________________________ How long: _______________

Present Position: ___________________________ Work Phone: _________________

Who will pay for this acct? ____________________ Referred by: _________________

Signature: ______________________________________ Date: __________________

Office Use Only Inputted by: ______________________ Date: _________________

Beth Heckman D.D.S. L.L.C.

Eaglesoft Medical History

Date 3/12/2015

Patient Name: _______________ Birth Date: ________ Date Created: 3/12/2015

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

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	

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?

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 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:___________

Beth Heckman, D.D.S., L.L.C.
422 East Main Street
Independence, Kansas 67301

Patient: ______________________________

1. I understand that payment for professional services is due at the time of treatment.
2. I understand that if the cost of professional services provided is covered by any form of dental insurance, your professional services are rendered and charged to me and not to the insurance company.
3. You have informed me that, if there is dental insurance, then, as a convenience to me, you will submit to the insurance company a claim for the professional services provided. I authorize you to do so. I understand that the insurance company may not pay the entire fee charged for professional services, and that I am expected to pay, on the day that the services are provided, that portion of the fees which will not be paid by the insurance company. That will include co-pays and any amounts, should there be any, over your annual maximum.
4. We are more than happy to help you maximize your dental insurance, and help follow-up on problems that may arise, but please remember that you are the subscriber of the plan. You have information regarding your plan that we do not have; therefore, we do not know all the specifics for each patient and cannot guarantee any payments that the insurance company will or will not make.
5. I authorize the insurance company to make payment directly to Beth Heckman, DDS, LLC.
6. I authorize you to include a copy of this document with all insurance claims submitted to the insurance company.
7. I am responsible for payment for professional services provided. I understand that if the insurance company refuses payment or does not pay in full, then I will be responsible for payment of the remaining outstanding balance.

Signed at Independence, Kansas.

Date: ____________________ Signature: ____________________________
Patient or person responsible for payment

Beth Heckman DDS LLC
422 E Main St
620-331-3580
620-331-3587

Authorization For Release of Identifying Health Information

Patient name____

Patient number ____

Patient address ____

Patient phone number ____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated__________________ Patient signature____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ____________________Print Name________________________________

Source of Authority____

Beth Heckman, D.D.S., L.L.C.
422 East Main
Independence, Kansas 67301
Office Phone: 620-331-3580
Fax: 620-331-3587

Minor/Child Consent

I, being the parent or guardian of ___________________________, do hereby request and authorize the dental staff to perform necessary dental services for my child, including x-rays, nitrous oxide (laughing gas), and administration of anesthesia and any services deemed advisable by the doctor, even if I am not present in the operatory during the dental treatment. ________Initial

Permission to Treat

Because your child is a minor it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor may deem necessary during the performance of her services. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient. Photos and other dental records of my child may be used for teaching or instructional purposes. ________Initial

Dental Treatment

I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary. ________Initial

Parent Signature:________________________________Date:_______________
Relationship to child: ______________________________