

NEW ROADS DENTAL

Patient Information

Name: _____ Date of Birth: _____

SSN: _____ Driver's License #: _____ E-Mail: _____

Address: _____ Suite/Apt: _____

City: _____ State: _____ Zipcode: _____

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

Employer: _____ Occupation: _____

Emergency CONTACT(NAME & NUMBER): _____

Were you referred by a patient? _____ If so who can we thank? _____

How long has it been since your last cleaning/dental visit? _____

How would you prefer to be contacted for recalls? Text Message Email Postcard

If patient is a Minor

Person responsible for Account _____ Date of Birth: _____

Relationship to Patient: _____ SSN: _____

Address (if different from above) _____ Suite/Apt# _____

City _____ State _____ Zipcode _____

DENTAL INSURANCE

Primary Dental Insurance: _____ ID# _____ Group _____

Name of Insured: _____ SSN: _____ DOB: _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF TREATMENT AND FOR THE FEES NOT PAID OR COVERED BY MY DENTAL INSURANCE. BALANCES OVER 30 DAYS WILL BE ASSESSED A BOOKKEEPING FEE OF 1.5% PER MONTH UNTIL PAID. THE PERSON RESPONSIBLE FOR THIS ACCOUNT AND/OR THE PATIENT WILL PAY ANY AND ALL COSTS INCLUDING ATTORNEY FEES IF COLLECTION BECOMES NECESSARY. WITH THIS SIGNATURE ON FILE YOU MAY PROCESS AND SUBMIT MY DENTAL CLAIMS TO MY INSURANCE CARRIER ON MY BEHALF. THERE MAY BE AN HOURLY CHARGE FOR APPOINTMENTS NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE.

DATE

SIGNATURE OF RESPONSIBLE PARTY, PARENT, GUARDIAN OR PATIENT

NEW ROADS DENTAL
Eaglesoft Medical History

Patient Name:

Birth Date:

Date Create:

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 could have an important interrelationship with the dentistry you will receive. Thank you for the answering the following questions.

- Are you under a physician's care now Yes No
- Have you ever been hospitalized or had a major operation? Yes No
- Have you ever had a serious head or neck injury? Yes No
- Are you taking any medications, pills, or drugs? Yes No
- Do you take, or have you taken, Phen-Fen or Redux? Yes No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No
- 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?

Are you use controlled substances? Yes No
 Other?

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above?

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:

Date:

Amanda Ewing Hazing. DDS

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____ SSA: _____

Address: _____ City: _____ State _____

Zip Code _____ Telephone: _____ D.O.B _____

Section B. To the Patient Read the Following Statements Carefully.

Purpose of Consent. By signing this form, you will consent to our disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting.

Contact Person: Amanda Ewing Haszinger, DOS

Telephone(225-)638-3384 Fax: (225)208-1009

Address. 2312 False River Drive, Ste C New Roads, La 70760

Right to Revoke. You will have the right to revoke this consent at any time by giving us written notice of revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. (Example) Patient has Dementia. Alzheimer Disease, and Communications Barriers or needs a Medical Consult for a Medical Condition; revocation would make treatment difficult or impossible.)

I, _____ have had full opportunity to read and consider the contents of this Consent form and you Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature _____ Date: _____

If this consent is signed by a person, guardian, or personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____