CENTURY DENTISTRY
Dr. Julie Lezotte, DDS

155 SW Century Drive Ste.102, Bend, OR 97702 Ph: 541- 382-7708 Fax: 541-382-1139 Email: centurydentistry@gmail.com

PATIENT NAME (Last, First, Middle Initial)		DATE OF BIRTH
ADDRESS		SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		MARITAL STATUS ❒ Single ❒ Married/Partner
HOME PHONE	CELL PHONE	SEX ❒ Male ❒ Female
PREFER ❒ Morning Appointment ❒ Afternoon Appointment		RELATIONSHIP TO INSURED ❒ Self ❒ Spouse ❒ Child
EMPLOYER		WORK PHONE
OCCUPATION		E-MAIL ADDRESS

If someone other than the PATIENT is responsible for payment, please complete the following:

RESPONSIBLE PARTY NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
BILLING ADDRESS	CITY/STATE/ZIP	PHONE

OTHER MEMBERS OF YOUR FAMILY SEEN BY THIS OFFICE

NAME	DATE OF BIRTH	RELATION:
NAME	DATE OF BIRTH	RELATION:

WHO SHOULD BE NOTIFIED LOCALLY IN CASE OF EMERGENCY?

NAME	PHONE
ADDRESS	RELATIONSHIP

INSURANCE INFORMATION

PRIMARY COVERAGE	SECONDARY COVERAGE (IF APPLICABLE)
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SOCIAL SECURITY/ID NUMBER	SOCIAL SECURITY/ID NUMBER
GROUP NUMBER	GROUP NUMBER
EMPLOYER	EMPLOYER

Preferred Local Pharmacy: _____

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

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?

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:_____

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Financial Arrangements and Office Policy

If you have dental coverage:

As a service to you, we will file your treatment with your insurance company. We will ***estimate*** your deductible and the portion not covered by your insurance company, however, we cannot be held responsible for the accuracy of the insurance information, nor do we base our recommended treatment on your insurance coverage. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. You hereby authorize any insurance benefits to be paid directly to the Dentist. You will be responsible for all services not covered by your insurance company.

Initials_____

Payment Of Services Rendered:

Payment for services is expected at time of service unless we approve other arrangements in writing prior to your appointment. You may choose to pay your portion at time of service by Cash, Check, Visa, Master Card, Discover and American Express. If you have a balance on your account, we will send you a monthly statement, which will show balance, new charges and payments or credits applied to your account during the month. Accounts are considered past due if not paid by the 25th of each month. There is a $50 fee for any checks returned by the bank. A finance charge may be imposed on each item of your account which had not been paid within thirty (30) days of the time the item was added to the account. **The FINANCE CHARGE** will be computed at the rate of one and one-half percent (1 ½%) per month or an **Annual Percentage Rate** of eighteen (18%) percent. If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred.

Initials_____

Office Policy:

We understand that unforeseen circumstances can arise; therefore, we will not charge you for a cancelled appointment if we receive notice ***48 hours before the appointment*** from you. Any No Show or canceled appointments are ***subject to a $50.00 charge.***

Initials_____

Cell phone and Children policy:

If you are an adult patient with a scheduled appointment, and have a child, please arrange for care of your child offsite. Staff members are not responsible for caring for your child during treatment and we cannot be held liable for an unsupervised child. Children are not allowed in the treatment area or on the patient's lap during treatment. This can be dangerous to the patient and distracting to the dentist. ONLY PATIENTS WILL BE PERMITTED IN THE TREATMENT AREA. A tranquil environment will allow us to provide the best treatment possible. No food or beverages are allowed in treatment area. Please be courteous to others and **turn off cellular phones**, as it disrupts our tranquil environment

Initials_____

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and affect.

I hereby assign all dental benefits, to include major dental benefits to which I am entitled, including private insurance and any other health plans, to Century Dentistry.

Patient's Printed Name: _____

Patient's Signature: _____ Date: __/__/__

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Notice of 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.

Print Patient Name: _____

Signature: _____ Date: __/__/__

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.

Print Patient Name: _____

Signature: _____ Date: __/__/__

CENTURY DENTISTRY

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NO SHOW/CANCELLATION POLICY

NO SHOW: If Patient "no shows" their appointment the account will be charged $50.00. Patients must pay this charge prior to scheduling another appointment. This fee is nominal and helps cover a fraction of the cost of staff.

CANCELLATION: Please allow a minimum of 48 hours to cancel an appointment. We understand circumstances arise that cannot be helped; however, we have RESERVED this appointment time for you and your dental needs. There will be a $50.00 charge to the account if the appointment is cancelled within 48 hours. This must be paid prior to scheduling another appointment.

Thank you for your understanding,

Dr. Julie

Patient Printed Name: _____

Patient Signature: _____ date:_____