BELVEDERE
FAMILY DENTISTRY
Lights • Camera • Smile

Thank you for choosing Belvedere Family Dentistry. To help us meet your entire dental healthcare needs, please fill out these forms completely. If you need any assistance or have any questions, please ask and we are happy to help.

Referrals are important to us! Please tell us how you heard about us:
Google_____Direct Mailer_____ Insurance_____Facebook _____Twitter_____ Other_____
If referred by someone, to whom may we thank for referring you? _____

How do you prefer us to contact you? Cell Phone / Home Phone / Email / Other_____

Name:_____Preferred Name: _____Sex : M F

Address:_____Home Phone:_____

City:_____State:_____Zip:_____Cell Phone:_____

SSN:_____ Date of Birth: _____Work Phone:_____

Email:_____

Patient or Parent/ Guardian Employer:_____Work Phone:_____

Employer Address: _____City: _____ State: _____ zip: _____

Emergency Contact: _____ Phone:_____

Responsible Party Information
Name of person responsible for account:_____
Address: _____ City: _____State: _____Zip: _____

Phone: _____Email:_____Relationship to Patient: _____

Insurance Information

Name of insured: _____Relationship to patient: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____Email:_____DOB: _____

Insurance Company: _____Name of Employer: _____

Policy/ID Number: _____Group Number: _____Ins Phone Number: _____

Patient/ Responsible Party Signature: _____Date:_____

Belvedere Family Dentistry

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

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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Medical History Form (continued)

Are you currently being treated for any of the following?

Multiple Myeloma	Yes	No
Breast Cancer	Yes	No
Osteoporosis	Yes	No
Prostate Cancer	Yes	No

Are you taking any of the following medications?

Any Bisphosphonates	Yes	No
Fosamax	Yes	No
Boniva	Yes	No
Actonel	Yes	No
Aredia	Yes	No
Zometa	Yes	No

Please list all medications that you are currently taking:_____

_____

_____

Patient's Name:_____ Date of Birth:_____

Patient's Signature:_____ Date of Birth:_____

Doctor's Signature:_____ Date Signed:_____

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Acknowledgement of Privacy Practices

Patient Name:_____ Date of Birth:_____

By signing below, I acknowledge that I have read and understand the office's Privacy Policy.

Patient Signature:_____ Today's Date:_____

HIPAA Authorization

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used for the following:

- Provide and coordinate my treatment among health care providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third party payers for my health services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I understand that I may request in writing how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that the office is not required to agree to my requested restrictions, but if they do agree they are bound to abide by such restrictions.

In addition to the allowable described above and in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my health care information to the person(s) listed below.

_____

_____

Patient Name:_____ Today's Date:_____

Patient or Legal Guardian's Signature:_____

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Dismissal Policy:

When patients no show, cancel at the last minute, or show up late for their appointments, it greatly effects our schedule, as well as other patient's appointments. Due to this, we require 24 hour notice to cancel and/or reschedule an appointment.

In the event that you may have more than three broken appointments, late cancellations, or frequently show up late for your appointment, you will be dismissed from our practice. Our voicemail does not accept any cancellations or changes to appointments. Please call back during normal business hours.

We also ask that you abide by the following rules while in our office so that we can serve your dental needs in the best way possible:

-NO food or drinks in the waiting area.
-Cell phones are NOT to be used in our office.
-If you are the parent or guardian of a child under the age of 18, you MUST remain in the office until all treatment is completed on the child.
-If you are more than 15 minutes late for an appointment, you may have to reschedule your appointment. When you are late, it counts towards our dismissal policy.

I understand my responsibilities as outlined above and will abide by them.

Patient's Name:_____Date:_____

Patient or Guardian's Signature:_____

Financial & Insurance Policies

We are committed to providing you with the highest quality of dental care using only the best materials and education available. In doing so, we have formulated the following policies to help keep the cost of dentistry down, and to continue to provide quality care to our valued patients.

Payment in full is due before services are provided. Our office accepts cash, official checks, MasterCard, and Visa. We will still estimate and bill out to insurance, but the remaining balance is due the same day that treatment is given.

If you have dental insurance, we will help you process your insurance claims. Please remember however, that you are responsible for the portion of your treatment not covered by insurance. We must also emphasize that as your dental care provider, our relationship is with you – our patient, not with your insurance company. Your insurance plan is a contract between you, your employer, and the insurance company.

Returned checks and balances older than 60 days will be subject to administrative fees and finance charges. Accounts submitted to court will be charged a $50 administrative fee. Additionally, charges of $50 will be incurred for broken appointments and appointments cancelled without 24-hour advance notice. Failure to give 24-hour advanced notice for the cancellation of an appointment may result in the office not being able to reappoint you.

If you have any questions or concerns about our policies, please feel free to ask the receptionist or manager on duty.

Best regards,

Daniel Lopez
Practice Manager

I understand my responsibilities as outlined above and agree to abide by them.

Patient's Name:_____ Today's Date:_____

Patient's Signature:_____Today's Date:_____