NORTH SPRINGS
FAMILY DENTISTRY

Date_____

Patient's Name Nickname

Address

City State Zip

Social Security Number Date of Birth

Home Phone Work Phone + Extension Cell Phone

E-Mail Address

Who can we thank for referring you?

INSURANCE

Name of Person Responsible for Account ***if Different Than You***

Relationship to Patient Birthdate SS#

Insurance Company Phone#

Address

Contact for Emergency:

Name _____ Relationship _____

Home Phone _____ Work Phone + Extension _____ Cell Phone _____

Dental Health History

Date of Last Exam _____ Dental X-rays _____

Former Dentist _____ Phone Number _____

Are your teeth sensitive to: (check all that apply) Cold_____ Hot_____ Sweets_____ Biting Pressure_____

Do your gums bleed when brushing? _____Yes _____No

Is there any unusual swelling in your mouth? _____Yes _____No

Have you at any time in your life worn braces? _____Yes _____No

Do you or have you ever had periodontal disease? _____Yes _____No

I hereby authorize payment directly to Dr. Russell Boyd, DMD, PC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor, provider, or any supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Eaglesoft Medical History(Updated)

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 medcation 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	

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

Do you use controlled substances?	○ Yes ○ No	If yes
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	Anaphylaxis ○ Yes ○ No
Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No	Anemia ○ Yes ○ No
Easily Winded ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No	Angina ○ Yes ○ No	Emphysema ○ Yes ○ No
High Blood Pressure ○ Yes ○ No	Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Shingles ○ Yes ○ No	Artificial Joint ○ 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	Kidney Problems ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No	Breathing Problems ○ Yes ○ No
Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No	Bruise Easily ○ 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	Mitral Valve Prolapse ○ 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	Heart Trouble/Disease ○ Yes ○ No
Psychiatric Care ○ 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:_____

NORTH SPRINGS
FAMILY DENTISTRY

Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstanding and facilitates processing of your insurance claim. If you have any questions, please ask us.
Thank you.

I understand and agree that I am responsible for the payment of all treatment fees on my account if my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Dr. Russell L Boyd, D.M.D.

As a courtesy we will try to verify your benefits by phone and estimate the amount not paid by the insurance company. We cannot be responsible for exact verbal verification. Therefore I understand and agree that I am responsible for the amount not paid by the insurance company.

I understand that after the insurance company pays Dr. Russell L Boyd, D.M.D. there could be a balance remaining, for which I am responsible.

I understand and agree that if upon payment by the insurance company, there is a remaining balance I am responsible for the amount in full at that time.

_____
Date

_____
Signature of Responsible Party

Russell L. Boyd, D.M.D., P.C.

Lake Ridge 400 Office Park

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770-351-9222 · E-mail: info@boydfamilydentistry.com

Acknowledge of Receipt of Notice of Privacy Practices

NORTH SPRINGS
FAMILY DENTISTRY

Russell L. Boyd, D.M.D., P.C.

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ *Other (Please Specify)*

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