

Kevin M. Easley D.M.D., P.C.

ACCOUNT INFORMATION

PATIENTNAME: \_\_\_\_\_ AKDL# \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SS#: \_\_\_\_\_ SEX: MALE OR FEMALE

MARTIAL STATUS: \_\_\_\_\_ MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

EMPLOYER PHONE: \_\_\_\_\_

NAME OF SPOUSE / PARENT: \_\_\_\_\_

SPOUSE / PARENT EMPLOYER: \_\_\_\_\_

INSURANCE INFORMATION

PRIMARY INS. CO. \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

SECONDARY INS. CO. \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

WHOM MAY WE THANK FOR YOUR REFERRAL?  
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HEALTH HISTORY INFORMATION

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

WHAT ARE YOUR SPECIAL INTERESTS OR HOBBIES? \_\_\_\_\_

WE ARE A HEALTH-CENTERED DENTAL PRACTICE; THUS WE ARE CONCERNED WITH YOUR TOTAL WELL BEING, NOT JUST YOUR ORAL HEALTH. AN ESSENTIAL PART OF OUR APPROACH IS A THOROUGH HEALTH HISTORY. PLEASE COMPLETE OUR QUESTIONNAIRE, EVEN IF SOME OF THE QUESTIONS MAY NOT SEEM RELEVANT TO DENTAL HEALTH. THANKS!

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:**

HYPOGLYCEMIA, DIABETES	Y	N	STROKE	Y	N
HEART ATTACK, HEART DISEASE	Y	N	HEART MURMUR	Y	N
HAY FEVER, ALLERGIES, ASTHMA	Y	N	RHEUMATIC FEVER	Y	N
HIGH BLOOD PRESSURE	Y	N	ANEMIA, BLOOD DISORDER	Y	N
CIRCULATORY PROBLEMS	Y	N	FAINING, BLACKOUTS	Y	N
NERVE DISORDER	Y	N	HEADACHES/MIGRAINES	Y	N
EXCESSIVE BLEEDING	Y	N	KIDNEY PROBLEMS	Y	N
HEPATITIS, JAUNDICE	Y	N	GLAUCOMA, EYE PROBLEMS	Y	N
LUNG PROBLEMS, TUBERCULOSIS	Y	N	ULCERS	Y	N
EPILEPSY, SEIZURES	Y	N	SINUS PROBLEMS	Y	N
BLOOD TRANSFUSIONS	Y	N	HIV POS. OR AIDS/ARC	Y	N
FACIAL/HEAD INJURIES	Y	N	OTHER: _____		
RADIATION TREATMENT	Y	N	_____		
MALIGNANCIES, CANCER	Y	N	_____		
RECENT WEIGHT GAIN OR LOSS	Y	N	_____		
ARE YOU PREGNANT NOW?	Y	N	_____		

HAVE YOU SEEN YOUR PHYSICIAN OR BEEN HOSPITALIZED IN THE LAST TWO YEARS?

IF YES, PLEASE EXPLAIN:

HAVE YOU HAD UNFAVORABLE REACTIONS TO: ANESTHETIC, NOVOCAINE, SEDATIVES, PENICILLIN, ASPIRIN, CODEINE, OTHER:

PLEASE LIST ANY DRUGS CURRENTLY TAKING: \_\_\_\_\_

HAVE YOU NOTICED ANY OF THE FOLLOWING?

TEETH TENDER TO CHEW ON?	Y	N	REOCCURRING SORES IN/AROUND MOUTH?	Y	N
DISCOMFORT IN FACE, HEAD, NECK?	Y	N	JAW CLICKING OR POPPING?	Y	N
FOOD CAUGHT IN BETWEEN TEETH?	Y	N	SENSITIVITY TO HOT OR COLD?	Y	N
BLEEDING OR SORE GUMS?	Y	N	SWELLING, LUMPS IN MOUTH?	Y	N
SENSITIVITY TO SWEETS?	Y	N			

HAVE YOU HAD ANY PROBLEMS WITH PREVIOUS DENTAL TREATMENT?

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**SMILE EVALUATION**

WE WOULD LIKE TO HELP YOU OBTAIN THE SMILE YOU'VE ALWAYS WANTED. PLEASE TAKE A FEW MINUTES TO COMPLETE THIS QUESTIONNAIRE.

ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH WHEN YOU SMILE? Y N

ARE THERE SPACES BETWEEN YOUR TEETH THAT YOU DON'T LIKE? Y N

ARE YOU PLEASED WITH THE SHAPE OF YOUR TEETH? Y N

ARE YOU PLEASED WITH THE COLOR OF YOUR TEETH? Y N

ARE YOU PLEASED WITH THE APPEARANCE OF YOUR GUMS WHEN YOU SMILE? Y N

ARE YOUR TEETH: CHIPPED PROTRUDING HIDDEN CROWDED

DO YOU LIKE THE WAY YOUR TEETH FIT TOGETHER WHEN YOU BITE DOWN? Y N

ARE THERE OLD FILLINGS OR DENTAL TREATMENT THAT YOU ARE NOT HAPPY WITH? Y N

IF YOU COULD CHANGE ANYTHING ABOUT THE APPEARANCE OF YOUR SMILE,  
WHAT WOULD IT BE?

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IS THERE ANYTHING ABOUT THE SHAPE OR ALIGNMENT OF YOUR JAW THAT YOU  
ARE NOT HAPPY WITH?

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## **FINANCIAL AND CANCELLATION POLICY**

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**Dr. Kevin M. Easley DMD, PC**

Payment is expected at the time of service. We accept all major credit cards (ask us about "extra credit"). Insurance billing is available as a courtesy. You are expected to pay your co-payment and any non-covered services at the time of service. We can only estimate your co-pay, but understand that you are responsible for all charges that the insurance company does not cover. We reserve the right to request a pre-treatment deposit on large cases. This deposit amount will be discussed when proposed treatment is presented.

### **FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:**

I, \_\_\_\_\_, authorize dental treatment. I agree to promptly pay all fees and charges for treatment provided to me and/or my family. I have read the policies above and understand them.

Insurance payment for services rendered should be assigned to Dr. Easley's office. I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full. I understand that I am responsible for all charges; whether or not they are covered by my insurance.

I authorize this office to release to my insurance carrier any medical/dental information needed to obtain payment for services rendered. I understand that if I disagree with the charges I will contact this office within 30 days of the billing date. Any past due balance forwarded to DCS Collections will have an additional fee added.

### **APPOINTMENT CANCELLATION AGREEMENT**

We charge a cancellation fee for all appointments that are not cancelled more than 24 hours in advance. This cancellation fee will be 25% of the treatment scheduled. We will request a credit card number to keep on file when long appointments are scheduled and a charge will be made in the event of cancellation. Multiple cancellations without 24 hour notice may result in dismissal from Dr. Easley's office.

I, \_\_\_\_\_, understand and agree to the above cancellation agreement.

\_\_\_\_\_  
RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
DATE

**KEVIN M. EASLEY D.M.D., P.C.**

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### **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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

\_\_\_\_\_  
Please Print Name

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Signature

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Date

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For Office Use Only

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You may leave a message regarding my personal health information on my answering machine/voicemail.

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Home Phone \_\_\_\_\_ or cell \_\_\_\_\_  
Work Phone \_\_\_\_\_