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

PATIENT INFORMATION

PATIENT NAME: _____AKDL#_____

BIRTHDATE: _____SS#:_____SEX: MALE☐ FEMALE☐

RELATIONSHIP 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? _____

WHAT ARE YOUR SPECIAL INTERESTS OR HOBBIES? _____

_____

HEALTH HISTORY INFORMATION

PATIENT NAME: _____

PHYSICIAN'S NAME: _____ PHONE #_____

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:

- ☐ ANEMIA, BLOOD DISORDER
- ☐ ARTIFICIAL JOINTS: YEAR _____
- ☐ BLOOD TRANSFUSIONS
- ☐ CIRCULATORY PROBLEMS
- ☐ EPILEPSY, SEIZURES
- ☐ EXCESSIVE BLEEDING
- ☐ FACIAL/HEAD INJURIES
- ☐ FAINTING, BLACKOUTS
- ☐ GLAUCOMA, EYE PROBLEMS
- ☐ HAY FEVER, ALLERGIES, ASTHMA
- ☐ HEADACHES/MIGRAINES
- ☐ HEART ATTACK, HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS, JAUNDICE
- ARE YOU PREGNANT NOW? HOW
- ☐ MANY MONTHS _____
- ☐ RECENT WEIGHT GAIN OR LOSS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV POS. OR AIDS/ARC
- ☐ HYPOGLYCEMIA, DIABETES: TYPE ____
- ☐ KIDNEY PROBLEMS
- ☐ LUNG PROBLEMS: COPD/EMPHYSEMA
- ☐ MALIGNANCIES, CANCER
- ☐ NERVE DISORDER
- ☐ RADIATION TREATMENT
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ SLEEP APNEA/SNORING
- ☐ STROKE
- ☐ TOBACCO/ALCOHOL USE:
  HOW OFTEN? _____ HOW MUCH? _____
- ☐ ULCERS
- ☐ OTHER: _____
  _____

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?
- ☐ DISCOMFORT IN FACE, HEAD, NECK?
- ☐ FOOD CAUGHT IN BETWEEN TEETH?
- ☐ BLEEDING OR SORE GUMS?
- ☐ SENSITIVITY TO SWEETS?
- ☐ REOCCURRING SORES IN/AROUNDMOUTH?
- ☐ JAW CLICKING OR POPPING?
- ☐ SENSITIVITY TO HOT OR COLD?
- ☐ SWELLING, LUMPS IN MOUTH?

HAVE YOU HAD ANY PROBLEMS WITH PREVIOUS DENTAL TREATMENT? _____

_____

SIGNATURE: _____ DATE: _____

SIGNATURE: _____ DATE: _____

SIGNATURE: _____ DATE: _____

SIGNATURE: _____ DATE: _____

FINANCIAL AND CANCELLATION POLICY

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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

Home Phone_____ or cell_____
Work Phone_____

General Consent for Dental Treatment

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

I understand the purpose of this general consent is to raise my awareness of risks that are common-place in many dental procedures. I understand my dentist reserves the right where appropriate (for example: for root canal therapy, extractions and other oral surgery, treatment of gum disease, placement or restoration of implants, crowns, bridges, and dentures) to provide me with a more specific informed consent discussion.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with it its own risks.

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity. For routine fillings, dental cleanings, prescription of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction to the anesthetic, or temporary or permanent injury to nerves and /or blood vessels from the injection. For oral surgery, I understand that there is always a risk of a post operative infection, nerve damage, and iatrogenic injury. In rare cases, the complications from surgery can be permanent, disabling, or even cause death. I understand the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation of dental instruments which may become lodged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact Dr. Easley a soon as possible.

I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment of surgery.

I have the right to ask Dr. Easley for more information if I have any concerns about my procedures and the possible side effects or complications. I promise to use that right to its fullest intent if for any reason I feel I am not fully informed about my procedure, the risk of the procedures, and my alternative to the procedure.

_____ ____/____/____

Patient/Guardian Signature Date