Time 8:41 AM | Thomas E. Wold, DMD | Date 5/14/2015

Eaglesoft Medical History

Patient Name: (2643) <No First Name> <N... Birth Date: Date Created: 5/14/2015

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

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

Other?	☐	If yes
Do you use controlled substances?	Yes No	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	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:_____

Thomas E. Wold, D.M.D.

124 NW Hawthorne Avenue
Bend, OR 97701

Statement of our Financial Policy

In the interest of a good health care practice, it is desirable to establish an office and credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

- You will need to provide our office with your social security number and health insurance card (if applicable) unless your total charge is paid in cash at time of service. Treatment may be postponed if the above are not furnished by the patient.
- We require payment in full by cash, check ($25.00 fee for any return checks) or bank card at the time of service. Alternate financing (Care Credit) must be arranged **before** treatment is rendered.
- Insurance patients – we require that the deductible and non-covered fees be paid at time of service.
- Bank charge cards – Visa, MasterCard, Discover, American Express and Debit cards are accepted.
- All home care products are to be paid in full at each appointment.
- There will be a $25 minimum and up to a $100 maximum charge for any broken appointment or appointment not cancelled with a **24 HOUR NOTICE.** The length of time scheduled for you determines the charge. We will not reschedule any patient after two appointments have been missed consecutively. Our time must be used as efficiently as possible to keep our expenses at a minimum and our fees within reasonable limits.

Our office staff understands dental insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract. It is important that you realize, however…..

- Your dental benefit program is a contract between you, your employer, and the insurance company. **We are not a party to that contract.**
- This office files your insurance claim as a courtesy to you, when you provide us with current information and any necessary forms. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account. We cannot accept responsibility for collecting an insurance claim after 90 days or for negotiating a disputed claim.
- Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your carrier.
- Not all dental services are a covered benefit in all contracts.
- Upon request, a pre-determined estimate of benefits can be given to you.
- We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. **We appreciate the opportunity to serve you.**

THERE IS NO INTEREST OR FINANCE CHARGE ON CURRENT ACCOUNTS. AFTER 90 DAYS, ALL ACCOUNTS ARE SUBJECT TO A FINANACE CHARGE OF 1.5% OF THE UNPAID BALANCE (or a minimum charge of $1.00) WHICH IS AN ANNUAL PERCENTAGE RATE OF 18%.

I have read this office and credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. I understand that delinquent accounts may be assigned to credit reporting collection service and I will be charged a $50 collection fee. Also, if it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

_____	_____
Signature of patient or parent/legal guardian	Date

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48hrs** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$50.00-$100.00** will be charged to your; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00-$100.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I,_____(print name), have received a copy of Dr.Wold's Appointment Cancellation Policy.

Signature of patient

Date

THOMAS E. WOLD, DMD

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

_____
(Or Signature of Legal Representative) **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**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

HEALTHCARE *COMPLIANCE* ASSOCIATES
PO Box 50598 ⊠ Eugene⊠⊠ OR 97405 ⊠ 541-345-3875 ⊠ Fax: 541-345-3939