

PLEASE COMPLETE THE FOLLOWING INFORMATION

PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Business Address: _____
Occupation: _____
Marital Status: Married Single Divorced Widowed

Birth Date: _____ Age: _____
Social Security #: _____
Drivers License #: _____
Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
E-mail Address: _____

SPOUSE/PARENT/GUARDIAN INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Business Address: _____
Occupation: _____

Birth Date: _____ Age: _____
Social Security #: _____
Drivers License #: _____
Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____

Seasonal Resident? Y____ N____ Date you leave: _____ Date you return: _____

Seasonal Out-of-Town Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: _____

Closest relative not living with you: _____ Relationship: _____

Address: _____ State: _____ Zip: _____ Phone #: _____

Do you know anyone who has been treated in our office? Y____ N____ Whom? _____

Who referred you to our office? _____

DENTAL INSURANCE INFORMATION

Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Group Name: _____

Subscriber's Name: _____
SSN#: _____
DOB: _____
ID#: _____
Group #: _____

PATIENT RESPONSIBLE FOR ALL FEES: All professional services rendered are charged to the patient or responsible party. Necessary forms will be completed to expedite insurance carrier's payment.

INSURANCE AUTHORIZATION: I hereby authorize Dr. Eastman to furnish information to my insurance carriers concerning my treatments, and I hereby assign to them all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance.

SIGNATURE ON FILE: _____ **DATE:** _____

Patient Consent to Receive Mail and/or Telephone Message

Last Name: _____ First Name: _____ MI: ____ DOB: _____

Do we have permission to:

Send a yearly appointment card to your home? Y____ N____

Send test results to your home? Y____ N____

Leave the following information on your home answering machine/voice mail?

Appointment Information Y____ N____

Billing Information Y____ N____

Medical Information Y____ N____

Leave the following information on your work answering machine/voice mail?

Appointment Information Y____ N____

Billing Information Y____ N____

Medical Information Y____ N____

Leave the following information on your cell phone voice mail?

Appointment Information Y____ N____

Billing Information Y____ N____

Medical Information Y____ N____

I give permission to share appointment information with the person named below:

Name: _____
(Last Name) (First Name) (Relationship)

I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:

Name: _____
(Last Name) (First Name) (Relationship)

Name: _____
(Last Name) (First Name) (Relationship)

I give permission to share billing information with the person listed below:

Name: _____
(Last Name) (First Name) (Relationship)

Signature of Patient: _____ Date: _____

HEALTH INFORMATION

1. Blood Pressure: _____ Pulse: _____ O2: _____
2. Have you been a patient in the hospital during the past two years? _____ Y____ N____
3. Have you been under the care of a medical doctor during the past two years? _____ Y____ N____
 Physician's Name: _____ Phone: _____
 Specialist's Name & Type: _____ Phone: _____
 Pharmacy Name: _____ Phone: _____
4. Are you taking any medication, drugs, pills, aspirin, vitamins, herb, or other over the counter medications? Y____ N____
 If yes, please list below: _____

5. Have you taken any antibiotics in the last 8 weeks? Y____ N____ What? _____
6. Are you taking or have you ever taken any of the following medications (if yes, when?): _____
 ___ Fosamax / ___ Actonel / ___ Aredia / ___ Didronel / ___ Zometa / ___ Boniva
7. Are you aware of being allergic to any medications or substances? Y____ N____ List allergies: _____

8. List previous surgeries: _____
9. Any complications with anesthesia in the past? Y____ N____ If yes, please explain: _____

10. List any joint replacements and year performed: _____
11. Circle any of the following which you have had or have at present:

Allergies or Hives	Chemotherapy	Glaucoma	HIV+/A.I.D.S.	Radiation Therapy
Anemia Cosmetic Surgery	Cold Sores	Heart Disease/Attack	Kidney Trouble	Sinus Trouble
Angina Pectoris Cough	Cortisone Medicine	Heart Failure	Liver Disease	Thyroid Disease
Arthritis/R.A.	Diabetes	Hemophilia	Osteopenia	Tuberculosis (TB)
Asthma Drug Addiction	Emphysema/COPD	Hepatitis A / B / C	Osteoporosis	Ulcers
Blood Transfusion	Epilepsy/Seizures	High Blood Pressure	Pain in Jaw Joint	
Canker Sores	Fainting/Dizzy Spells	High Cholesterol	Psychiatric Treatment	
12. Have you had a heart attack, stroke, or cardiac stent placed in the last 6 months? Y____ N____
13. Do you pre-medicate with antibiotics for dental appointments? Y____ N____ Antibiotic Type: _____

Artificial Heart Valve	Heart Murmur	Heart Surgery	Rheumatic Fever
Artificial Joints(Hip, Knee)	Heart Pacemaker	Mitral Valve Prolapse	Scarlet Fever
14. Current use of tobacco products? _____ Y____ N____
 Packs per day: _____ Type: _____ When Stopped: _____
 Past use of tobacco products? Y____ N____ # Years used: _____ When stopped: _____
15. How frequently do you drink alcohol? Daily Weekly Occasionally Never
16. Has your medical doctor ever said you have cancer or a tumor? _____ Y____ N____
17. Do you have any disease, condition, or problem not listed? _____ Y____ N____
18. Height: _____ Weight: _____

19. Are you pregnant? Y_____ N_____ If yes, how far along are you? _____ Are you taking birth control pills? Y_____ N_____

20. Name of Obstetrician: _____

DENTAL HISTORY:

Dentist's Name: _____ How Long?: _____

How many times a year do you have your teeth cleaned? _____ Date last cleaned ____/____/____

Do you floss daily? Yes No How/who made you aware of a concern in your mouth? _____

Are you having pain or discomfort at this time? _____ Y_____ N_____

Do you feel nervous about having dental treatment? _____ Y_____ N_____

Have you had a bad experience in the dental office? _____ Y_____ N_____

Do you have a concern with losing your teeth or someday wearing dentures? _____ Y_____ N_____

Do you notice a bad taste/odor in your mouth? _____ Y_____ N_____

Tender/bleeding gums when brushing? _____ Y_____ N_____

Do you feel your teeth are loose? _____ Y_____ N_____

Are your teeth sensitive to hot/cold? _____ Y_____ N_____

Have you had an oral abscess? _____ Y_____ N_____

Does food trap easily between teeth? _____ Y_____ N_____

Are you aware of clenching or grinding your teeth? _____ Y_____ N_____

Do you have a tendency to gag? _____ Y_____ N_____

Do you have difficulty breathing through your nose? _____ Y_____ N_____

Do you have any concerns with getting numb? _____ Y_____ N_____

Do you have a back problem that will prevent you from lying back in our chair? _____ Y_____ N_____

Do you have headaches? Y_____ N_____ Upon awakening? Y_____ N_____ Under Stress? Y_____ N_____

Have you undergone orthodontics (braces)? Y_____ N_____ When? _____ Where? _____ Dr.? _____

Have you seen a periodontist before? Y_____ N_____ When? _____ Where? _____ Dr.? _____
What was done at the time? _____

Please make additional comments you feel we should know. _____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT: _____ DATE: _____

WITNESS: _____ DATE: _____



Eastman Periodontics and Implants, PLLC

Periodontics, Implants and Laser Surgery

Excellence you can trust for over 35 years

Notice of Privacy and Financial Guidelines

Welcome to the office of Dr. Lindsay Eastman, Periodontal and Dental Implant Specialist. Our financial goal is to offer state of the art treatment at an affordable investment leading to improved oral health.

Courtesy Insurance Filing Service:

Our office strives to offer the highest level of care to our patients and does not belong to any dental insurance plans. We base our recommendations on the *needs of our patients* rather than the *limitations of insurance benefits*. As a courtesy and convenience to you, we will file your claims for all services and procedures with your dental insurance company. Sometimes your policy will not pay for services, testing or medications that we may feel are medically recommended. Since coverage rules change often, it is not possible for us to always know what your particular coverage may be. We advise you to acquaint yourself with your policy and to call your insurer regarding any coverage questions. We will always work with you to do the best for your health and well-being, and we look forward to sharing the benefit of our years of experience with you. For more information on what your insurance may or may not pay, please visit us online at <https://www.eastmanonline.com/faq/>.

Payment at Time of Service:

Please provide payment at the time the service or procedure is performed. For your convenience, we accept Visa, MasterCard, Discover, American Express, Apple Pay, check or cash. For patients without insurance, *Care Credit* is available and affordable for any budget. Visit <http://www.carecredit.com>.

Missed Appointments:

If you cannot keep your scheduled appointment, please let us know at least 48 hours in advance. There **will** be a \$35 fee charged for non-surgical related appointments missed without 48-hour notice, except in the case of an emergency. All surgical appointments that are cancelled within 48 hours **will** incur a \$500.00 fee.

Fee for Returned Checks:

For checks written in payment of our services, which are returned for insufficient funds, there will be a \$35 processing charge.

Questions?

If you have any questions about your financial responsibilities or our payment guidelines, please do not hesitate to ask. We look forward to getting to know you and to enjoying a win-win relationship with you.

Dental Insurance Signature on File:

I, the undersigned, have insurance with the carrier named on the insurance information document prepared by me today. I will notify this office immediately of any changes to my insurance coverage. I authorize payment of dental benefits directly to Dr. Lindsay B. Eastman, Dr. Christie E. Craighead, and/or Dr. Justin C. Craighead for professional services rendered. I am financially responsible for all charges for such services rendered to me, including the balance remaining after the payment of any insurance benefits. I permit a copy of this authorization to be used in place of the original, and authorize the release of any dental or other information necessary to process a claim on my behalf.

Notice of Privacy and Financial Guidelines

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Release of Dental Information: I authorize the release of any and all dental information necessary to communicate with all medical and dental related personnel. I also authorize the release of any and all dental information necessary to process this claim.

Release of Photos: I authorize the release to use my name, statements/quotes, and likeness without charge, for promotional purposes in publications, advertising, video, web, new media, or other formats.

Fax clearance:

I give my permission to fax any and all records with the understanding that there is a possibility that this information may be misdirected.

Exclusions:

I have listed below the people to whom I **do not** want Dr. Lindsay B. Eastman, Dr. Christie E. Craighead, and/or Dr. Justin C. Craighead to disclose any part of my medical or health information:

Notice of Privacy Practices Acknowledgement:

I hereby acknowledge that I have seen and read the "Notice of Privacy and Financial Guidelines" for Dr. Lindsay B. Eastman, Dr. Christie E. Craighead, and/or Dr. Justin C. Craighead and that I have been given an opportunity to ask questions concerning the "Notice of Privacy and Financial Guidelines." I understand that I may have a paper copy should I so desire and that a copy of this policy will be made available upon my request.

Financial Agreement:

I understand that I am directly responsible for my account, the payment of this account and I hereby assume and guarantee payment of expenses incurred by myself and/or my dependents. Should legal action be required to secure payment of this account, I agree to pay reasonable collection expenses, all court costs and a reasonable attorney's fee incurred thereby.

Compliance Statement:

I have read and I understand the financial guidelines above and I agree to abide by them.

Patient or Responsible Party

Date



STATEMENT OF PATIENT RESPONSIBILITY

As a service to our patients, we will submit all necessary paperwork to your insurance carrier. However, our office has no contact or affiliations with insurance companies of any sort. Your policy is an agreement between you and your insurance company. You are responsible for your total obligation should your insurance company pay less than anticipated. The fees charged for services are the usual and customary fees charged to all of our patients for similar services. Please remember that due to the exceptional variations in insurance coverage, our office cannot be abreast of the details of each insurance plan. It is the patient's responsibility to ensure that they understand the details of their own plan as it relates to annual deductibles, yearly maximums, and exclusions for certain periodontal procedures.

If you cannot keep your scheduled appointment, please let us know at least 48 hours in advance. There will be a \$500 cancellation fee charged for surgical appointments missed without 48-hour notice, except in the case of an emergency.

I CERTIFY THAT I HAVE READ, UNDERSTAND, AND ACCEPT ALL TERMS SET FORTH ABOVE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL TREATMENT RENDERED.

Patient Signature

Date

Financial Coordinator

Date



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Medicare Opt-Out Private Contract

This contract between Dr. Lindsay B. Eastman, Christie E. Craighead, and/or Justin C. Craighead ("Dentists") And _____ (Medicare beneficiary, referred to in this contract as "Patient") allows Dentist to provide treatment to Patient without being subject to Medicare limits. To do so, the law requires Dentist to "opt out" of Medicare and that no Medicare claim be filed for the treatment of Patient by Dentist.

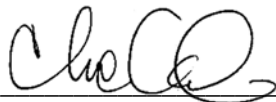
Dentist represents that Dentist is excluded from participation under the Medicare program under §1128, 1156 or 1892 of the Social Security Act; in addition, Patient and Dentist agree that Patient is not now facing an emergency or urgent health care situation.

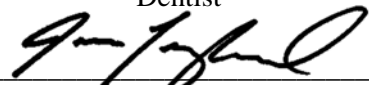
By signing this contract, Patient agrees to the following:

- i. Agrees not to submit a Medicare claim (or to request that Dentist submit a claim) for services or items supplied by Dentist, even if they are otherwise covered under Medicare;
- ii. Agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Dentist, and understands that no reimbursement will be provided under Medicare for those services or items; [add if applicable: in particular, Patient will pay for such services at Dentist's usual rate (or any other agreed upon rate), in accordance with Dentist's payment policies];
- iii. Acknowledges that Medicare limits do not apply to amounts that Dentist may charge for such services or items;
- iv. Acknowledges that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for items and services covered by this contract, because payment is not made under Medicare; and;
- v. Acknowledges that Patient has the right to have such services or items provided by other dentists or practitioners for whom payment would be made under Medicare. (Patient is not required to enter into private contracts that apply to other Medicare covered services furnished by other dentists who have not opted out.)

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of the Dentist's current opt-out period. The expected expiration date of Dentist's opt-out period is 9/25/2017.

Accepted and Agreed: 
Dentist


Dentist


Dentist

Accepted and Agreed: _____
Patient or Patient's
Legal Representative