PLEASE COMPLETE THE FOLLOWING INFORMATION

PATIENT INFORMATION:

Name: _____ Birth Date: _____ Age: _____
Address: _____ Social Security #: _____
City:_____ State:_____ Zip:_____ Driver's License #: _____
Employer: _____ Home Phone #: _____
Business Address:_____ Work Phone #: _____
Occupation: _____ Cell Phone #: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed E-mail Address: _____

SPOUSE/PARENT/GUARDIAN INFORMATION:

Name: _____ Birth Date: _____ Age: _____
Address: _____ Social Security #: _____
City:_____ State:_____ Zip:_____ Driver's License #: _____
Employer: _____ Home Phone #: _____
Business Address:_____ Work Phone #: _____
Occupation: _____ Cell Phone #: _____

Seasonal Resident? Y_____ N_____ Date you leave: _____ Date you return: _____

Seasonal Out-of-Town Address: _____

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

Emergency Contact: _____ 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: _____ Subscriber's Name:_____
Address: _____ SSN#:_____
City:_____ State:_____ Zip:_____ DOB:_____
Phone #: ___(_____)_____ ID#: _____
Group Name: _____ 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:**_____

Dr. Lindsay B. Eastman, D.D.S., M.S., P.A.

Patient Consent to Receive Mail and/or Telephone Message

Last Name: _____ First Name: _____ MI: ___ DOB: _____

What is your preferred method of communication? (Circle one)

Cell Phone / Home Phone / Work Phone / Email / Mail

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, diet 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☐

Taking antibiotics may make oral contraceptives ineffective!

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:**_____

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
Page two

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

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.

Accepted and Agreed: _____
Dentist

_____
Dentist

_____
Dentist

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