EASTMAN CRAIGHEAD

PERIODONTICS • IMPLANTS • LASER SURGERY

PLEASE COMPLETE THE FOLLOWING INFORMATION

PATIENT INFORMATION:

Name: _____ Birth Date: _____ Age: _____
Social Security #: _____

PARENT/GUARDIAN INFORMATION:

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

Father's Name: _____Birth Date: _____ Age: _____
Address (**if different than above**): _____Social Security #: _____
City:_____ State:_____ Zip:_____ Driver's License #: _____
Employer: _____ Home Phone #: _____
Business Address:_____ Work Phone #: _____
Occupation: _____ Cell Phone #: _____

With whom does child live? Mom_____ Dad_____ Other_____ If **other,** what is the relationship? _____

Emergency Contact: _____

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:**_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:**_____

PATIENT CONSENT TO RECEIVE MAIL AND/OR PHONE MESSAGES

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 in
formation 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, drug/alcohol addictions [if any], positive HIV status, etc.) with all members of your medical and dental team as well as 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:** _____

Parent/Guardian Signature: _____ **Date:** _____

HEALTH INFORMATION

Patient Name:_____ Height: _____ Weight:_____

1. Have you been a patient in the hospital during the past two years? Yes No Explain: _____

2. Have you been under the care of a medical doctor during the past two years?_ Yes No Explain:_____
   Physician's Name:_____ Phone:_____
   Specialist's Name & Type:_____ Phone:_____
   Specialist's Name & Type:_____ Phone:_____
   Pharmacy Name:_____ Phone:_____

3. Are you taking any medications, oral contraceptives, aspirin, vitamins, herbs, or other over the counter medications? Y___ N___
   If yes, please list below: _____ _____ _____
   _____ _____ _____ _____

4. Have you taken any antibiotics in the last 8 weeks? Yes No Antibiotic name: _____

5. Are you taking or have you ever taken any of the following medications? Yes No Last dose:_____
   □ Fosamax □ Actonel □ Aredia □ Didronel □ Zometa □ Boniva □ Prolia □ Reclast Frequency:_____

6. Are you aware of being allergic to any medications or substances? Yes No List allergies: _____

7. List previous surgeries / joint replacement(s): _____

8. Any complications with anesthesia in the past? Yes No If yes, please explain: _____

9. Family history of anesthesia complications? Yes No If yes, please explain: _____

10. Circle any of the following which you have had or have at present:

Allergies or Hives	Cancer / Chemotherapy	Glaucoma	HIV+/A.I.D.S.	Rheumatoid Arthritis
Anemia Cosmetic Surgery	Radiation Therapy	Heart Disease / Attack	Kidney Trouble	Sinus Trouble
Angina Pectoris Cough	Cortisone Medicine	Heart Failure	Liver Disease	Thyroid Disease
Arthritis	Diabetes 1 or 2: A1C_____	Hemophilia	Osteopenia	(Hyper / Hypo)
Asthma	Drug Addiction	Hepatitis A / B / C	Osteoporosis	Tuberculosis (TB)
Blood Transfusion	Emphysema / COPD	High Blood Pressure	Pain in Jaw Joint	Tumor
Canker Sores / Cold Sores	Fainting / Dizzy Spells	High Cholesterol	Psychiatric Treatment	Ulcers

11. Have you had a heart attack, stroke, or cardiac stent placed in the last 6 months? Yes No Explain: _____

12. Do you pre-medicate with antibiotics for dental appointments? Yes No Antibiotic type:_____
    □ Artificial Heart Valve □ Heart Murmur □ Heart Surgery □ Rheumatic Fever
    □ Artificial Joints (Hip, Knee) □ Heart Pacemaker □ Mitral Valve Prolapse □ Scarlet Fever

13. Current use of tobacco products? Yes No Type: _____ Frequency: _____ # Years used:_____
    Have you used tobacco products in the past? Yes No # Years used: _____ When stopped: _____

14. Recreational drug use (marijuana, kratom, heroin, etc)? Yes No Type: _____ Frequency: _____

15. How frequently do you drink alcohol? □ Daily □ Weekly □ Occasionally □ Never

16. Do you have any disease, condition, or problem not listed? Yes No Explain: _____
    Are you pregnant? Yes No If yes, how far along are you? _____

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? _____

Do you have a concern with losing your teeth or someday wearing dentures?.....YES NO

Do you notice a bad taste/odor in your mouth?..... YES NO

Tender/bleeding gums when brushing?..... YES NO

Do you feel your teeth are loose?..... YES NO

Are your teeth sensitive to hot/cold?..... YES NO

Have you had an oral abscess?..... YES NO

Does food trap easily between teeth?..... YES NO

Are you aware of clenching or grinding your teeth?..... YES NO

Do you have a tendency to gag?..... YES NO

Do you have difficulty breathing through your nose?..... YES NO

Do you have any concerns with getting numb?..... YES NO

Do you have a back problem that will prevent you from lying back in our chair?..... YES NO

Do you have headaches? Yes No Upon awakening? Yes No Under Stress? Yes No

Have you undergone orthodontics (braces)? Yes No When?_____ Where?_____ Dr.?_____

Have you seen a periodontist before? Yes No 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.

Signature of Patient / Guardian: _____ Date:_____

Reviewed by **(**team member name**):** _____ Date**:**_____

For Office use - Patient vitals: Blood pressure: _____ Pulse:_____ O2 saturation:_____

Notice of Privacy and Financial Guidelines

Welcome to Eastman Craighead Periodontics. Our financial goal is to offer state of the art treatment at an affordable investment leading to improved oral health.

Insurance Filing Service:
Our office strives to offer the highest level of care to our patients and is not contracted with any dental insurance companies. 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.

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, cash and financing options with 3rd party lenders.

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

(Continued)

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

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

Fax clearance:
I give my permission to fax 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, Dr. Justin C. Craighead and/or Dr. Rachael Voight 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.

CBCT Scans
Eastman Craighead Periodontics uses CBCT scans to help diagnose and treat patients for a fee of $175 per scan. Sometimes we offer CBCT scans at no cost, under specific conditions. If a patient receives a complimentary scan but then seeks a second opinion and requires a copy, they must pay the full $175 fee. Payment is required before the copy is released. Please note - Our practice does share CBCT scans with other professionals working together in the patient's care, such as their restorative dentist, endodontist, and orthodontists.

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

EASTMAN CRAIGHEAD

PERIODONTICS + IMPLANTS + LASER SURGERY

Medicare Opt-Out Private Contract

What is a Medicare Opt-out Contract?
Our office has "opted-out" of Medicare. This means that neither the physician nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare.

This contract between Dr. Lindsay B. Eastman, Christie E. Craighead, Justin C. Craighead and/or Rachael Voigt (referred to in this contract as "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:

- 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;
- 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];
- Acknowledges that Medicare limits do not apply to amounts that Dentist may charge for such services or items;
- 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;
- 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) (Dentist)

Accepted and Agreed: _____

(Patient or Patient's Legal Representative)

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