Patient Information

Patient Name: _____ Driver's License #: _____

Address: _____ City: _____ State: __ __ Zip: _____

Home Phone: _____ Cell phone: _____ Other: _____

Email address: _____ May we contact you by email? (circle) Yes No

Patient Social Security Number: _____ Patient Date of Birth: _____ Sex: (circle) M F

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Emergency Contact: _____ Relationship: _____ Phone: _____

Preferred Pharmacy: _____

How did you hear about our office?

○ Yelp ○ Google ○ Facebook ○ Friend/Family: _____ ○ Other: _____

Responsible Party (if not the Patient) _____ **Phone:** _____

Relationship: _____ **Date of Birth:** _____ **SSN:** _____

Email address: _____ **May we contact you by email? (circle) Yes No**

Insurance Information

Do you have Dental Insurance? (circle) Yes No

Subscriber Name: _____ Date of Birth: _____ Subscriber SSN: _____

Relationship to Subscriber: ○ Self ○ Spouse ○ Child ○ Other

Name of Insurance: _____ Phone #: _____

Employer Name: _____ Group Number: _____ Policy ID #: _____

Insurance Billing Address: _____

Please circle Yes or No to the following questions.

Do you clench or grind your teeth? Y N Have you ever been told you snore? Y N

Do you have dental anxiety? Y N Have you ever had orthodontic (braces) Treatment? Y N

How do you feel about your smile? _____

BUCKINGHAM DENTAL

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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:_____

Buckingham dental

FINANCIAL POLICIES

PAYMENT: Payment is due in full at the time of service, unless prior arrangements have been made. We accept cash, personal checks, most major credit cards, debit cards, and third party financing through Care Credit.

INSURANCE: As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, estimated co-payments, and non-covered amounts are due at the time services are rendered. All estimates quoted are based upon information provided to us by your insurance company and are **estimates only and are not a guarantee of payment.** Please remember that the contract itemizing your dental benefits is between you, your employer (if applicable), and your insurance company. Dental insurance plans are not designed to cover all of your dental needs. Many dental plans have waiting periods, frequency limitations, and alternate benefit clauses. Some plans may not cover certain procedures at all. The patient is ultimately responsible for all charges incurred. **We urge you to be aware of your policy plan provisions.**

Insurance companies are required by law to pay claims within 30 days. After 60 days, any unpaid claims will become the sole responsibility of the patient. At that time outstanding amounts to insurance will be required to be paid in full by the patient. Our first and only priority is to our patients and their quality of care.
Our goal is to help you maximize your dental insurance benefits. However, remember that you, and not your insurance carrier, are ultimately responsible for payment for all services rendered in our office.

PLEASE NOTE: WE WILL BE CONSIDERED OUT OF NETWORK ON ALL DMO AND SOME PPO INSURANCE PLANS.

RETURNED CHECKS: All returned checks are subject to a $30.00 returned check fee. After a check has been returned, all future payments will be on a cash or credit card basis.

DELINQUENT ACCOUNTS: Accounts over 90 days past due will be handled by our collection service. The patient agrees to pay ALL collection costs in addition to fees for service.

CANCELLATIONS: It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only. This allows us to focus our efforts on caring for and treating our patients to the best of our abilities. Thus, we require a minimum of 24 hour notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. Lack of adequate notice inhibits us from offering an exceptional standard of care to our other patients. A fee of $100 per hour scheduled may be charged for failed appointments, inadequate notice of cancellation, or rescheduling of an appointment with less than 24 hour notice. We appreciate your cooperation and respect of our efforts.

I have read the above and I understand and agree to these terms regarding my treatment by Brad Buckingham, D.M.D.

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Buckingham Dental
6800 Burnet Rd Ste 5
Austin, TX 78757

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of **Buckingham Dental**'s *HIPAA Notice of Privacy Practices.*

I understand that **Buckingham Dental**'s *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Buckingham Dental**"s revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about **Buckingham Dental**"s *HIPAA Notice of Privacy Practices*, I may contact **Buckingham Dental.**

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Buckingham Dental** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Buckingham Dental**'s privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask **Buckingham Dental**', noted above, for assistance.

_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
	_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Buckingham Dental' made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices.* In spite of these efforts, **Buckingham Dental**' was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID