PATIENT INFORMATION

PATIENT_____ HOME PHONE_____
Last First Middle
EMAIL(OPTIONAL)_____ CELL PHONE_____

ADDRESS_____ BUS. PHONE_____

CITY_____ STATE_____ ZIP CODE_____

EMPLOYER_____ SOCIAL SECURITY #_____

DATE OF BIRTH___/___/___ SEX M☐ F☐ SINGLE☐ MARRIED☐ WIDOWED☐ DIVORCED☐

INSURANCE POLICY HOLDER_____ DATE OF BIRTH___/___/___

SEX M☐ F☐ SINGLE☐ MARRIED☐ WIDOWED☐ DIVORCED☐

POLICY HOLDER ADDRESS (if different from patient) _____

RELATION TO PATIENT: SELF☐ SPOUSE☐ PARENT☐ OTHER☐

EMPLOYER_____

PRIMARY DENTAL PLAN_____ COMPANY PHONE_____

PLAN ADDRESS_____

GROUP #_____ MEMBER ID #_____

NAME OF PREFERRED PHARMACY _____ PHONE _____

NAME OF EMERGENCY CONTACT_____ PHONE_____

IS ANY MEMBER OF YOUR IMMEDIATE FAMILY A PATIENT HERE?_____

WHO REFERRED YOU TO OUR OFFICE?_____

GENERAL DENTIST NAME_____

CANCELLATION POLICY

We understand that on occasion cancellations are necessary. Please remember that each appointment time is reserved exclusively for that individual patient. Therefore, we require 48 hours notice to reschedule or cancel an appointment. This enables us to offer that appointment to someone else who needs it. Thank you for making every effort to keep your appointments.

PERMISSION FOR TREATMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable.

PROMISE OF PAYMENT

I hereby authorize Matthew D. Ficca, DMD, MSD, PA to furnish information to insurance carriers concerning services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. We ask that payment is rendered at the time of service. As part of our service to you, we file your insurance claim, in an attempt to speed up and maximize the benefit you are entitled, for re-imbursement directly to you.

_____

SIGNATURE OF PATIENT DATE

MATTHEW D. FICCA, D.M.D.,M.S.D.,P.A.

Eaglesoft Medical History(Copy)

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

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

Matthew D. Ficca, DMD, MSD, PA

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Matthew D. Ficca, DMD, MSD, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders
(provide name and phone number) ☐ Spouse_____ ☐ Parent_____ ☐ Other(i.e. Relative, Friend, Caregiver)_____	☐ Financial ☐ Treatment Plans/ Treatment
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment/Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected. ****We do not process appointment changes via text or email. You must call the office at 704-544-2224 for changes or cancellations.*	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2018

MATTHEW D. FICCA, DMD, MSD, PA

ACKNOWLEDGEMENT 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}

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)

_____

_____

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).