ARC DENTAL INC

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

Question	Answer	If yes
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	
Do you use controlled substances?	○ Yes ○ No	If yes

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 have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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 above? ○ Yes ○ No If yes

Comments: Dr. Fernando Marchetti D.D.S.

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:__________

Arc Dental Inc.

Dr. Fernando Marchetti D.S.S.

Date ___/___/_____

PATIENT REGISTRATION

First Name:______________________ Last Name:________________ Middle initial: _____

Patient is : → Policy Holder [ ] Responsible Party [ ]

Responsible Party (if someone other than the patient)

First Name:______________________ Last Name:________________ Middle initial: _____

Address :____________________ City __________ State_______ Zip Code________

Birth Date: ___/___/_____ Home Phone: ( ) ______ ______ Cellular : ( ) ______ ______

Social Sec: :________________ Driver License: ________________

[ ] *Responsible Party is also a Policy Holder* [ ] *Primary Insurance Policy Holder* [ ] *Secondary Insurance Policy Holder*

Patient Information

Address :____________________ City __________ State_______ Zip Code________

Birth Date: ___/___/_____ Home Phone: ( ) ______ ______ Cellular : ( ) ______ ______

Sex: → Male___ Female___ Marital Status → [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Social Sec: :________________ Driver License: ________________

E-mail: ______________________________ [ ] I would like to receive correspondences via e-mail

PRIMARY INSURANCE INFORMATION

Name of Insured: ______________________ Member ID:________________

Relationship to insured: Self ___ Spouse___ Depend child___ Other ________________

Social Sec: :________________ Insured Birth Date: ___/___/_____

Employer :____________________

Address :____________________

City __________ State ___ Zip Code________

Insurance Company: ____________________

Address :____________________

City __________ State ___ Zip Code________

SECONDARY INSURANCE INFORMATION

Name of Insured: ______________________ Member ID:________________

Relationship to insured: Self ___ Spouse___ Depend child___ Other ________________

Social Sec: :________________ Insured Birth Date: ___/___/_____

Employer :____________________

Address :____________________

City __________ State ___ Zip Code________

Insurance Company: ____________________

Address :____________________

City __________ State ___ Zip Code________

FINANCIAL AGREEMENT

Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental Insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods. etc. is entirely" YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

- We accept cash Visa, MasterCard Discover and Amex.
- After your dental insurance has paid its portion, a statement is sent to the mailing address on record. For the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.
- If the insurance company does not pay in full within 30 days, it will be your responsibility to ensure you're insurance company pays promptly so you can avoid finance charges, or remit the full balance within two weeks.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A **$25.00** charge applies when a check is retuned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid

within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees. court fees and any other fees associated with the collection of your debt.

RECORDS AND REIMBURSEMENTS: original records including radiographs are the property of this office. If you desire we will provide you with a copy of your record or radiographs for a nominal duplication fee.

SPECIAL NOTE ON THE DELIVERY OF CROWNS AND OTHER PROSTHETICS: A temporary crown is not considered the finished product and it is strongly recommended that all patients make and keep their appointment for the delivery of a permanent crown and other prosthetics. Your dental health depends on it, and we must insist upon it as ethical dental health providers. Please come back for the delivery of your permanent crowns and other prosthetics.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees.

Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of **Arc Dental Inc**. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Name: ______________________________ Signature: ______________________

Patient Name: ______________________________ Date: ____/_____/_____

Are you the person legally responsible for this child? Yes: _____ No: ______

BROKEN OR MISSED APPOINTMENTS: To reschedule or cancel an appointment, you must notify us at least forty-eight (48) hours in advance to avoid a missed appointment fee. We take them seriously so please be considerate and inform us in advance if you need to change your appointment. . Broken appointments prevent others from receiving the dental care they deserve. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

Cancellation of Appointments

I agree to keep all scheduled appointments unless I notify the office at least 48 hours prior to the appointment. I understand that failure to keep a scheduled appointment may result in a missed Appointment fee of **$25** per hour scheduled.

Signature: ______________________________ Date: _____/______/______

ARC DENTAL INC.
Dr. Fernando Marchetti D.D.S.

Acknowledgment of Receipt of Privacy Practices Notice & Dental Material Fact Sheet

I. Acknowledgment of Receipt of Privacy Practices Notice:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Initials: _________

II. Acknowledgement of Receipt of Dental Materials Fact Sheet

Initials: _________

____ ___/___/_____

Signature of Patient/Parent/Guardian Date

NOTIFICATION TO CONSUMERS DENTAL HYGIENISTS ARE LICENSED AND REGULATED BY THE DENTAL HYGIENE COMMITTEE OF CALIFORNIA

(916) 263-1978
WWW.DHCC.CA.GOV

How did you hear about ARC Dental?

[ ] Family Member -> Name: ______________________________

[ ] Friend/Co-Worker -> Name: ______________________________

[ ] Insurance Provider List

ONLINE

[ ] Website [ ] Google [ ] Yelp [ ] Twitter [ ] Facebook
[ ] Other: ____________________

Medical Doctor/Other -> Dentist Name: __________________________

We love Referrals

The Greatest Compliment our office can receive is when You Our Valued Patient Refers us a Friend or Family Member. So each time you do, we would like to say Thank you with a special gift. Please remind your family and friends to tell us that you kindly referred them to us, when they call to schedule & keep their appointment.

Thank You!

www.arcdentalmodesto.com

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