Time 2:03 PM

Pleasant Dental Center

Date 2/27/2019

Updated 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.

Question	Answer	
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:__________

Signature of Doctor:

X Date:__________

GEORGE A. EZZI, D.M.D.

Pleasant Dental Center

126A Pleasant Valley Street Suite 4 Methuen, MA 01844

P: 978-688-9200 F: 978-688-4949

Email: pleasantdentalcenter@comcast.net

Informed Consent For General Dental Procedures

You the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be provided

I understand that during my course of treatment that the following care may be provided:

Examinations	Preventative Services	Periodontal Treatment
Restorations	Root Canal	Local Anesthesia
Removable Appliances	Crowns	Bridges

Patient Initials__________

2. Drugs and Medications

I understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient Initials__________

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restoratives procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials__________

____
Patient name (please print)

______________________________   ______________
Signature (patient, parent or guardian)   Date

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Written Financial Policy

Thank you for choosing Pleasant Dental Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose from:

- Cash, Check, Visa, MasterCard, American Express, Discover or Care Credit

For our patients without dental insurance we offer a 10% discount if services are paid in full prior to treatment with cash or check.

We offer a senior citizens (65+) discount of 10% for patients without dental insurance paying with cash or check.

Please note:

Pleasant Dental Center requires payment prior to the beginning of your treatment.

For treatment plans $500 or more a 20% deposit is required to schedule your initial treatment appointment.

Patients with a dental insurance, as a courtesy to you, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 is charged for patients who miss or cancel an appointment without 24 hour notice. Our office reserves the right to discharge a patient who accrues two or more missed appointments.

Pleasant Dental Center charges $25 for returned checks and a finance charge on any outstanding balance.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_________________________ _________________________ _______________.

Signature (patient, parent or guardian) Print name of Patient Date

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HIPAA Release Form

Name:____

Date Of Birth:____/____/____

Release of Information

- I authorize the release of information including the diagnosis, records, examination rendered to me, financial and claims information. This information may be released to:
- Spouse:______________________________
- Parent(s):____________________________
- Other:_______________________________

- Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed:_____________________________ Date:____/____/_____

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Cell Phone and Email Use Policy

I provide the consent to Pleasant Dental Center to use my cell phone number to

- o Call
- o Text regarding appointments
- o Leave a message
- o Email

I consent to Pleasant Dental Center to call using my cell phone regarding dental treatment, insurance, and my account. I understand that I can withdraw this consent at any time.

My phone number is: ______________________________

Email: ____________________________

Patient Signature: ________________________

Date: ____________________

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Pre-Med Questionnaire

Has anyone (doctor, dentist) told you that you need to pre-medicate before dental treatment due to heart murmur, hip or joint replacement?

YES NO

If YES- reason for pre-med: ______________________________

Are you taking a daily dosage of Aspirin? ______ Dosage: _____

Dr.'s Name: ______________________________

Dr.'s Address: ____________________________

Dr.'s Tel.#: ______________________________

____________________ ____________________________
Print name of Patient Signature (patient, parent or guardian)

____
Date

RECORDS RELEASE FORM

Date ____________

To ____
(Previous Office/Doctor name)

Address ____

City ____________ State ____________ Zip____________

Phone # __________________ Fax# ____________________

I authorize the release of my dental records and medical records relevant to dental treatment, or copies of such, and request that they are transferred to:

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Please list any other family members:

Name	Relationship
1. ________________________	__________________
2. ________________________	__________________
3. ________________________	__________________
4. ________________________	__________________

______________________________ ______________________________

Print name of Patient and SS# Signature (patient, parent or guardian)