# EAGLE EYE DENTAL

**MICHAEL SOMAI, DMD**

104 S. Cory Dr. Edgewater, FL 32141

Phone 386-957-3977 Fax 386-957-3979 Info@EagleEyeDental.com


## PATIENT REGISTRATION

First Name:_____ Last Name:_____ Middle Intial:_____

Preferred Name:_____ Sex:_____ Male _____ Female

Address:_____ City:_____

State:_____ Zip Code:_____

Phone Number: Home:_____ Cell:_____ Work:_____

Birth Date:_____ Social Security Number:_____

Drivers License: State:_____ Number:_____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____

Employer:_____ Phone Number:_____

Email Address:_____

Responsible Party:_____ Relationship:_____

Phone Number:_____

Emergency Contact:_____ Phone:_____

PRIMARY INSURANCE INFORMATION:

Name of Insured:_____

Insured Social Security:_____ Birth Date:_____

Employer:_____

Work Phone Number:_____

Insurance Company:_____

ID Number:_____ Group Number:_____

Insurance Company Address:_____

Insurance Company Phone Number:_____

How Did You Hear About Our Office?_____

Time 12:45 PM

Michael Somai, DMD

# Eaglesoft Medical History

Date 2/17/2023

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, c

| | | |
|---|---|---|
| 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?

| | | | |
|---|---|---|---|
| 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:

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:_____

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# BLOOD THINNER CONSENT

I, _____, have made Eagle Eye Dental, and their staff aware that I am taking the following blood thinners before my procedure:

____ Pradaxa (Dabigatran)

____ Xarelto (Rivaroxaban)

____ Eliquis (Apixaban)

____ Warfarin (Coumadin)

____ Plavix (Clopidogrel)

____ Fish Oil

____ Garlic

____ Vitamin E

____ Gingseng

____ Ginkgo Biloba

____ Aspirin

____ Other Blood Thinners

Patient Signature:_____

Date:_____

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# Unconfirmed Appointments

**Unconfirmed appointments** will not be guaranteed. If we leave a message, please call our office back to confirm your appointment.

**If unconfirmed**, you may be asked to reschedule to the next available time or date.

Pt. Signature:_____

Date:_____

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# FINANCIAL POLICY

Your health is first and foremost. Medical care will always be rendered on the basis of need and no other factor will affect the quality of that care.

This is an agreement between Eagle Eye Dental as creditor, and the Patient/Debtor named on this form. By executing this agreement, you are agreeing to pay for all the services received.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show the current total patient balance that is the patient/debtor's responsibility.

PAYMENT OPTIONIF YOU HAVE NO INSURANCE: You may choose to pay by:

_____ Cash, _____Check, _____,Credit Card, _____,OR _____ Care Credit, on the day of treatment .

PAYMENT OPTION IF YOU HAVE INSURACE: You choose to pay your deductible and any other out-of-pocket portion at the time services are rendered by: _____Cash, _____ Check,_____, OR _____ Credit Card.

INSURANCE: We will bill your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay all the charges not covered by insurance or all the charges deemed YOUR responsibility.

EFFECTIVE DATE: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

THERE WILL BE A 35.00 PROCESSING FEE FOR ALL RETURNED CHECKS.

Patient Name:_____

Responsible Party:_____

Signature of Patient:_____

Date:_____

Signature of Responsible Party:_____

Date:_____

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# Cancellation and Broken Appointment Policy

We ask our patients to give us a 24 hour notice whenever possible if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

POLICY FEES:

OUR OFFICE REQUIRES AT LEAST 24 HOURS FOR ALL APPOINTMENT CANCELLATIONS. IF YOU ARE UNABLE TO PROVIDE 24 HOURS NOTICE, YOU WILL BE BILLED A 35.00 CHARGE FOR YOUR SCHEDULED APPOINTMENT TIME.

Definition of "Broken Appointment": A broken appointment is when you

*Cancel or reschedule an appointment with less than 24 hours notice.

* Do not show up for the scheduled appointment.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing adequate notice, this adds to the overall cost of care. Our trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us at Eagle Eye Dental.

I have read and understand the above mentioned policy.

Patient Signature:_____ Date:_____

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***ACKNOWLEDGEMENT OF RECIEPT OF***

***HIPPA NOTICE AND PRIVACY PRACTICE***

***("Acknowledgement")***

I acknowledge that I have received a copy of this Dental Practice's HIPPA Notice of Privacy Practices.

_____

***PATIENTS NAME (PLEASE PRINT)***

_____

***PATIENTS SIGNATURE***

What is the preferred way you can be reached?

_____/_____

***PHONE NUMBER*** ***AND /OR*** ***EMAIL ADDRESS***

The following person (or class of persons) may receive disclosure of protected heath information about me:

_____ _____

***NAME*** ***RELATIONSHIP TO PATIENT***

_____ _____

***PHONE NUMBER*** ***EMAIL***

_____ _____

***SIGNATURE OF PERSONAL REPRESENTATIVE*** ***AUTHORITY OF PERSONAL REPRESENTATIVE***

***WARNING: THERE IS SOME RISK THE PROTECTED HEALTH INFORMATION COULD BE READ OR ACCESSED BY A THIRD PARTY WHILE IN TRANSIT.***