Wall Street Dentistry
Patient Information

Name_____
Last First M

Address_____
Street Appt# City State Zip

Home Phone_____ Cell_____ Work_____

Email_____ Referred By_____

We have the ability to confirm your appointment by text, email or phone call.
Please select your confirmation preference: ☐ Text ☐ Email ☐ Phone Call

DOB_____ SSN#_____ Employer_____

Sex_____ Marital Status_____ Spouse Name_____

Responsible Party_____

Address_____

Insurance Information

Primary Insurance Policy Holder	**Secondary Insurance**
Name_____	_____
Address_____	_____
DOB_____	_____
Relationship_____	_____
Employer_____	_____
Ins Company_____	_____
SS#_____	_____
Subscriber #_____	_____
Group #_____	_____

Emergency Contact Information:

Name_____ Phone #_____

I agree to pay at the time services are rendered or as otherwise agreed. In the event that this account is turned over to a collection agency, I will be responsible for all collection fees, court costs and attorney fees. I authorize Wall Street Dentistry to release information to my insurance carriers concerning my diagnosis and treatments and I hereby assign to the dentist all payments for medical/dental services rendered.

Signature _____ Date _____

Time 9:03 AM | Wall Street Dentistry, LLC | Date 10/29/2015

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.

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:_____

Authorization, Release & HIPPA Consent

NAME **DATE**

AURTHORIZATION, ASSIGNMENT AND RELEASE

I hereby give my consent to the doctors, team and associates of Wall Street Dentistry to provide dental services to myself and/or family.

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Wall Street Dentistry all insurance benefits, if any, otherwise payable to me for the services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

INITIAL_____

INSURANCE POLICY

Changes made daily among insurance companies make it impossible for us to accept the responsibility of knowing if your plan dictates benefits, payment, coverage and whom you can and cannot see. As a service to you, we will file your insurance claim. In order for us to file your insurance, please provide all insurance information **NO LESS THAN ONE WEEK BEFORE YOUR VISIT**. **It remains the responsibility of the patient to know his or her own plan.** As a service to you, we will call your insurance company for an estimate of what they will pay. It is important to know that any information given over the phone cannot be guaranteed and is only an **estimate**. The day of your exam, we require you to pay your estimated difference between insurance payments and the provider charges.

INITIAL_____

FINANCIAL POLICY

In order to help reduce our administrative costs and to keep our fees to you as low as possible, we require payments to be made at, or prior to, the time you receive treatment. We do charge a $30 fee for returned checks. Our goal is to eliminate "billing surprises", so let us help you plan your treatment carefully by addressing your financial concerns before treatment begins.

We are pleased to offer these payment options for payments made to Wall Street Dentistry :

-Cash
-Check
-Major Credit Card (Visa, Master Card, and Discover)
-Care Credit, an interest free payment plan (with approved credit)

INITIAL_____

Appointment Policy

Wall Street Dentistry charges a $25 fee for any appointments canceled without a 24 hour notice. Your insurance will be notified of your failure to show, which may result in an increase in your premiums. You will be responsible for the missed or failure to show fee.

INITIAL_____

HIPPA CONSENT

By signing this form you consent to your use and disclosure of protected health information about you for treatment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Wall Street Dentistry may condition treatment upon the execution of this consent.

Additionally, by signing this form you acknowledge that by presenting yourself as a patient or child, you consent for dental and medical care by Dr. Jonathan Renfroe , Dr. Josh Conley and team of Wall Street Dentistry. You hereby grant full authority to Dr. Jonathan Renfroe, Dr. Josh Conley, respective assistants and hygienist to administer and perform any and all medications, treatments, tests or diagnostic procedures to or upon you, which may be advised or necessary.

All health information may be shared with_____ RELATIONSHIP_____

PATIENT_____DATE_____

SIGNED BY_____RELATIONSHIP_____

WITNESS_____

Wall Street Dentistry
65 Wall Street, Albertville, AL 35951
Jonathan Renfroe, DMD Josh Conley, DMD
p. 256-878-0525 f. 256-878-0521

Notice of Privacy Practices
Patient Acknowledgement

Patient Name:_____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- **A description of uses or disclosures that are prohibited or materially limited by law.**
- **A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.**
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - **The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.**
    - **The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested** restriction.
    - **The right to receive confidential communications of protected health information.**
    - **The right to inspect and copy protected health information.**
    - **The right to receive an accounting of disclosures of protected health information.**
    - **The right to obtain a paper copy of the Notice of Privacy Practices from this** practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practice's on request.

Signature: _____ Date:_____
Relationship to patient (if signed by a representative of patient)_____