Suzanne E. Bird DDS, MS, PA

Eaglesoft Medical History

Patient Name: Birth Date:

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

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

Other? If yes

Do you use controlled substances? Yes No 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 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:__________

WELCOME TO BIRD PEDIATRIC DENTISTRY & ORTHODONTICS!

PATIENT INFORMATION

Date ________________

Child's Name ____
Last *First* *Middle*

Address ____
Street *City* *State* *Zip*

Home Phone:____________________ Birth Date:________________ Social Security #:____________________

Child's School:________________________ Grade in School: ______________________________

Any Siblings? & Ages?____

Who Does Child Live With: ____

RESPONSIBLE PARTY INFORMATION

Email Address________________________________ Drivers License #______________ *State*________

Name ____
Last *First* *Middle* *Marital Status*

Residence ____
Street *City* *State* *Zip*

Mailing Address ____
Street *City* *State* *Zip*

How long at this address ____________

Previous Address (if less than 3 years) ______________________________
Street *City* *State* *Zip*

Home Phone____________________ Work Phone____________________ Cell Phone____________________

Social Security #__________________ Birth Date________________ Relationship to Patient ______________

Employer______________________ Occupation______________________________ No. Years Employed ______

Spouse's Name____ Relationship to Patient ____________
Last *First* *Middle*

Spouse's Employer____________________________ Occupation________________ No. Years Employed ________

Spouse's Social Security #____________________ Spouse's Birth Date________ Cell Phone: ______________

DENTAL INSURANCE INFORMATION

Insured's Name______________________________ DOB__________ Insured's Soc. Sec. # ______________
Insurance Company__________________________ Phone #____________________ Group # ______________
Insured's Employer______________________________________ Insured's ID # ____________________
Do you have secondary coverage? Yes ☐ No ☐ If Yes, please continue: ____________________________
Insured's Name______________________________ DOB__________ Insured's Soc. Sec. # ______________
Insurance Company____________________ Phone #__________________ Group # ____________________
Insured's Employer______________________________ Insured ID #______________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____
Home #____________________ Cell Phone__________________ Relationship to Patient ______________

Signature____ Date ______________
I understand that where appropriate, credit bureau reports may be obtained.

Medical History for ______________________ (child's name)

Child's Physician: ______________________ Date last seen: ______________

1. Is your child presently under the care of a physician for any medical problems? ∆ Yes ∆ No

What? ______________________

2. Is your child currently taking any medications? ∆ Yes ∆ No

What? ______________________

3. Has your child ever been hospitalized or had surgery? ∆ Yes ∆ No

For what? ______________________

4. Does your child have any allergies to any medicines, food, or latex? ∆ Yes ∆ No

What? ______________________

Has your child had history of? **(Check only if answer is "YES")**

- ⌡ Heart trouble or murmur
  Pre-med needed? ∆ Yes ∆ No
- ⌡ Rheumatic fever
- ⌡ Seizures
- ⌡ Diabetes
- ⌡ Kidney/liver problem
- ⌡ Asthma
- ⌡ Hepatitis
- ⌡ Other ______________
- ∆ Frequent headaches
- ∆ Learning disorder
- ∆ Brain injury
- ∆ Bleeding problems
- ∆ HIV positive/AIDS
- ∆ Cancer
- ∆ Tuberculosis

Dental History

How did you hear about our practice? ______________________

What brings you here today?

- ⌡ Dental cleaning/check-up
- ⌡ Toothache/trauma
- ⌡ Orthodontics (braces)
- ⌡ Referred by another dentist for fillings/extractions

1. Is this your child's first dental visit? ∆ Yes ∆ No

Previous dentist:

____

2. Has your child had an unfavorable experience from dental care in the past?

⌡ Yes ∆ No; Please Explain ______________________

3. Do you have any specific concerns about your child's teeth? ______________________

____

4. Do you have any other children that might need to be seen? ______________________

____

Patient Name:

Patient address:

PATIENT POLICIES CONSENT

1. A treatment plan will be presented if your child has treatment needs at their initial office visit. Dr. Bird and/ or her associates will use their professional judgment with regards to type of filling recommended (white composite, silver amalgam, or stainless steel crown). If you have a preference to the type of material to be used, please verbalize it prior to the restorative appointment. All reasonable efforts will be made to meet your request.
2. Please be aware that occasionally treatment plans may change unexpectedly. You (the responsible party) will be responsible for the difference in fee, if there is one.
3. We allow parent presence during initial examination and cleaning appointments. At appointments for treatment and application of orthodontic appliances, Dr. Bird and her associates request that your child comes back to the treatment area alone, as this enables us to provide full attention to them and allows us to work with them without distraction. Most children tolerate treatment better without their parent present.
4. Children under the age of 8 are seen during our morning hours, starting at 8:00 A.M. through 12:00 PM., depending on the work to be performed. Certain types of appointments require particular lengths of time and attention and therefore are scheduled at specific .times of the day.

Your signature indicates that you have read, understand and agree to Dr. Bird and her associate's policies above.

Signature: **DATE:**__________________

FINANCIAL CONSENT

1. Payment is generally expected for service rendered at the time of the visit. We accept cash, Care Credit, Chase Health, Visa, MasterCard, Discover, and American Express payments. We gladly accept checks but will need the license number and state of the person issuing the check. Checks are automatically drafted through our Telecheck system and a $35 fee will be issued by your bank for insufficient funds.
2. You, the responsible Party of the patient, are responsible for 100% of the treatment fees. We do accept insurance assignment as a courtesy to our patients. For all proposed treatment, we estimate your portion and the insurance company's. This is our in-office estimate. We cannot guarantee either eligibility or coverage, but we will use this estimate as a rough guideline until final payment has been received from your insurance company. At that time, we will reconcile the account and bill or refund you any difference. We are not responsible for insurance claim disputes or negotiation of disputed claims.
3. In the event your account becomes more than 90 (ninety) days past due, it will be referred to our collections department to ensure account performance and will accrue interest at a maximum allowable legal rate. You will be responsible for all fees associated with the collection activities, attorney's fees and court costs.
4. Cancelled appointments with less than 24 hours' notice, or if you do NOT show up to your appointment, you will be charged up to a $50 per patient occurrence.

Your signature indicates that you have read, understand and agree to Dr. Bird and her associate's policies above.

. **Signature:** **DATE:**__________________

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Bird Pediatric Dentistry & Orthodontics

Acknowledgment of Receipt Of Notice of Privacy Practices

Patient Name and Address:____

____

I have received or been offered a copy of the Notice of Privacy Practices for the above-named practice.

______________________________ ____________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

( ) An emergency existed and a signature was not possible at the time.

( ) The individual refused to sign.

( ) A copy was mailed with a request for a signature by return mail.

( ) Unable to communicate with the patient for the following reason:

____

( ) Other:____

____

Prepared by: ____

Signature:____

Date:____________________________

Authorization for Release of Information – Compound Release

Name of Patient____Date of Birth ______________

BIRD PEDIATRIC DENTISTRY is authorized to release protected health information about the above named patient in the following manner and to persons listed.

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	☐ Results of lab tests/x-rays Other________________________
☐ Spouse (provide name and phone number) ______________________________	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) ______________________________	☐ Financial ☐ Medical
☐ Other (provide name & phone number) ______________________________	☐ Financial ☐ Medical
☐ Email communication-Provide email address* ______________________________ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification

☐ For **email 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 move forward to allow email communications to occur.

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.

The information is released at the patient's request and 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)

\\bddsas007\!netshare_data\front desk or office proced\authorizationforrelease-compoundmay2014a.doc

____

INFORMED CONSENT FOR VIDEO RECORDING FOR SAFETY, SECURITY, TREATMENT PURPOSES AND IMPROVED PATIENT CARE

Name of Patient (print): ______________________ Date of Birth: ______________

Address: ____

City, State, Zip: ______________________ Phone: ______________

It is the policy of **Bird Pediatric Dentistry ("BPD")** to provide the highest quality dental services to our patients, prospective patients and their family members. To ensure a high level of care, as well as the safety and security of our patients, the premises of BPD are under continual video surveillance. I/We acknowledge and consent voluntarily that the video surveillance may be monitored and/or recorded for safety, security, treatment purposes and improved patient care.

______________________________ ______________

Signature of Patient or Legal Representative Date

______________________________ ______________

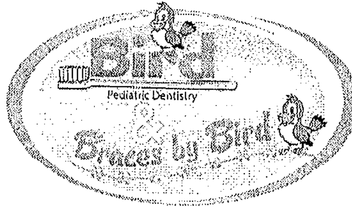
Witness Date

C:\Forms\Bird - Informed Consent to Video Monitoring (Patient - BPD) REVISED.docx
9/23/16

Suzanne E. Bird DDS, MS, PA

www.birddentistry.com

16607 Riverstone Way, Suite 300, Charlotte, North Carolina 28277 t. 704.544.5000 f. 704.544.5003



Social Media Photography and/or Video Consent

Patient Name: ______________________________ Account #: ____________

I consent to have my child's (or an individual to whom I provide guardianship) image and/or video testimonial taken by the staff at **Bird Pediatric Dentistry** as described below.

I understand that my child's (or an individual to whom I provide guardianship) photograph and/or video footage may be used to help promote Bird Pediatric Dentistry. The images and/or video footage may be used to assist in the development of website, social media, print and art materials. I understand that Bird Pediatric Dentistry will own these images, by may email them to me in an unencrypted email communication as selected.

I understand that Bird Pediatric Dentistry has agreed not to use the images and/or video footage for reasons other than what is outlined above without first receiving written authorization from me.

I may revoke or withdraw this consent any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient, or have authority to give consent for the patient. My questions regarding this consent form have been answered.

______________________________ ____________

Parent or Guardian Signature Date

____

Printed Name

____

Email Address

Consent to use on Social Media (please circle one): **Yes No**