

Julie O Childers, DMD PA

700 Plaza Circle- Suite M Clinton, SC 29325

864-833-5673

WRITTEN FINANCIAL POLICY

Thank you for choosing Julie O Childers DMD PA. 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:

1. Cash, Check, Visa, MasterCard, Discover or American Express

We offer a 5% courtesy discount adjustment to patients who pay for their treatment with cash in full prior to completion of treatment of \$1000.00 or more.

2. Care Credit Monthly Payment Plan: (Subject to Credit Approval)

Allows you to pay over a 12 month period with no interest

No annual fees or pre-payment penalties

Please Note:

Julie O Childers, DMD PA requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, in the event any refund is due, it will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements (may) be provided.

For patients with dental insurance, we will gladly file your insurance as a courtesy. However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and also collection of your benefits directly from your insurance carrier.

Julie O Childers DMD PA has a \$35.00 returned check fee.

If you have any questions, please do not hesitate to contact our office. We are here to help you get the dentistry you want/need.

Patient Name (Please Print)

Date

Patient, Parent or Guardian Signature

Date

JULIE CHILDERS DMD
Eaglesoft Medical History 2

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

Do you see a physician regularly?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Date of your last physical exam?	_____	
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Do you smoke?	<input type="radio"/> Yes <input type="radio"/> No	If yes _____
Do you use smokeless tobacco?	<input type="radio"/> Yes <input type="radio"/> 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

Any allergies not listed? ☐ Yes ☐ No 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 <input type="radio"/> Yes <input type="radio"/> No	Corticosteroid Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No
Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No
Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Blood Disease <input type="radio"/> Yes <input type="radio"/> No
Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No
Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No
Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No	Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No
Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No	Chest Pains <input type="radio"/> Yes <input type="radio"/> No
Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No
Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No
Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
Venereal Disease <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No	Depression <input type="radio"/> Yes <input type="radio"/> No	Autism <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

Dental History

What is the reason for today's visit? _____

When was your last visit to a dentist? _____

Do you have or have you had any of the following? (Please check all that apply to you)

Bleeding gums <input type="radio"/> Yes <input type="radio"/> No	Broken teeth or fillings <input type="radio"/> Yes <input type="radio"/> No	Chronic bad breath <input type="radio"/> Yes <input type="radio"/> No	Decayed teeth <input type="radio"/> Yes <input type="radio"/> No
Food catching between teeth <input type="radio"/> Yes <input type="radio"/> No	Grinding or clenching teeth <input type="radio"/> Yes <input type="radio"/> No	Injury to teeth or jaw <input type="radio"/> Yes <input type="radio"/> No	Loose teeth <input type="radio"/> Yes <input type="radio"/> No
Periodontal disease <input type="radio"/> Yes <input type="radio"/> No	Painful or locking jaw <input type="radio"/> Yes <input type="radio"/> No	Sensitivity to sweet, hot, cold, biting <input type="radio"/> Yes <input type="radio"/> No	Sores, growths or swelling in mouth <input type="radio"/> Yes <input type="radio"/> No

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: _____

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient☐ Primary Insurance Policy Holder☐ Secondary Insurance Policy Holder

Patient Information

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: ☐ Male ☐ FemaleMarital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ RetiredStudent Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

e-mail _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone Number: _____

E-mail Address: _____

Patient Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

I hereby authorize _____
Name of individual(s) and/or organization providing information

to release the above-described information to _____
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____. If I do not
Expiration date or event
specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: _____ Date: ____/____/____

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

Received by: _____ Date: ____/____/____