JESSICA EAGAN DDS
Cosmetic Dentistry | Implant Dentistry | Family Dentistry

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)

Address _____ Address 2 _____

City, St., Zip _____ Birth Date _____

Home Phone _____ Soc. Security _____

Cell Phone _____ Drivers Lic. _____

Work Phone _____ Referred By _____

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

Patient Information :: Section 1

Address _____ Address 2 _____

City, St., Zip _____ Birth Date _____

Home Phone _____ Drivers Lic. _____

Cell Phone _____ E-Mail _____

Work Phone _____ Soc. Security _____

Sex ☐ Female ☐ Male Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Primary Insurance Information

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

Insured Social Security _____ Insured Birth Date _____

Employer _____ Insurance Company _____

Employer Address _____ Address _____

City, St., Zip _____ Address 2 _____

Rem. Benefits _____.00 Rem. Deduc _____.00 City, St., Zip _____

Secondary Insurance Information

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

Insured Social Security _____ Insured Birth Date _____

Employer _____ Insurance Company _____

Employer Address _____ Address _____

City, St., Zip _____ Address 2 _____

Rem. Benefits _____.00 Rem. Deduc _____.00 City, St., Zip _____

FEES AND INSURANCE INFORMATION

All fees are payable at the times services are rendered. We accept all major credit cards. Your dental insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charge's is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency, I authorize said attorney to obtain my credit report and I understand that I will be liable for any charges incurred, including reasonable attorney's fees, court costs and collection expenses.

RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Jessica Eagan DDS of all benefits applicable and otherwise payable to me for my insurance carrier or other third party payer, for services rendered by Jessica Eagan DDS. I understand that I am financially responsible for any and all charges that the carrier declines to pay. I hereby authorize release of dental records as deemed necessary for payment of benefits.

Patient's / Guarantor's Signature _____ Date _____

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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 many 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, please explain _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain _____
Do you take, or have taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphoaphonates? ☐ Yes ☐ No If yes, please explain _____
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sicle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis (TB)
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

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

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 _____ **Date** _____

JESSICA EAGAN DDS
Cosmetic Dentistry | Implant Dentistry | Family Dentistry
2340 Coral Way | Miami, FL 33145/ T: (305) 856-1178 F: (305)-239-9452

CONSENT FORM

Patient's Name: _____ Date: _____

I hereby authorize Dr. Jessica Eagan and her assistants, to perform upon me all necessary dental procedures.

I request and authorize the Doctor to do whatever they deem advisable if any unforeseen condition arises in the course of these designated operations and procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (i.e. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not exact Science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient's Signature: _____ Date: _____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT
OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal privacy law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office at (305) 856-1178.

_____
Patient's Name (Please Print)

_____ _____
Signature Date

_____
Patient's Legal Representative (if applicable)

_____ _____
Signature of Legal Representative Date

For Dental Office Use Only

We attempted to obtain write ACKNOWLEDGMENT of receipt of our Notice of Privacy Practices, but ACKNOWLEDGEMENT could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the ACKNOWLEDGEMENT
- An emergency situation prevented us from obtaining ACKNOWLEDGEMENT
- Other (please specify)

_____
_____

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Cancelled and Missed Appointments

Please be advised that every appointment given is exclusively reserved for you as a patient. Any missed appointments without cancellation or rescheduling prevent us from providing for your dental care needs. If you have schedule conflicts, we will be happy to work with you in rescheduling at a time convenient for you. A cancellation call **24 hours prior** to your appointment date will be greatly appreciated. Failure to call in advance will result in a **$50 cancellation fee**. This charge will be applied to your account and must be paid PRIOR to you scheduling any other appointments.

By signing below you are confirming that you read and understand the following policy.

Patient Name (Please Print):_____

Patient Signature: _____ Date: _____

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Patient Photo Release Form

I _____, hereby authorize Jessica Eagan DDS or any of their assignees to take photographs, slides, and videos of my teeth, jaw, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook and instagram posts, etc). I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (name) will not be used. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

_____I approve of my photographs being used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

_____I do not want my photographs to be used.

Patient's Signature_____Date_____