Laura Gramse, R.D.H., D.M.D.
1055 Park Street
P.O. Box 67
Palmer, MA 01069

FINANCIAL AGREEMENT

Methods of Payment

1. Cash, Check or Credit Card (MasterCard, Visa, American Express, Discover)
2. Dental Insurance (Described Below)
3. Care Credit (application available) or any other 3rd Party Financing

Dental Insurance

1. We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company. **We will need you to bring us a copy of your benefit booklet if you would like help interpreting your benefits.**

2. As a courtesy to you, we will file your insurance and accept assignment of benefits. **We ask that your estimated co-payment be paid at the time of service.**

_____I am authorizing my insurance company to make payments directly to Dr. Laura Gramse.

_____I choose not to assign benefits and will pay for my treatment at the time of service.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.

RELATED INFORMATION

1. Returned checks will be subject to a $25.00 fee.
2. Account balances older than 30 days will be subject to a $10.00 per month billing fee and 1.5% interest charge.
3. In the event that the account is not paid, and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees).
4. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. 24 hours' notice is needed to avoid a $50.00 charge.
5. There is a $35.00 fee that will be applied to the account if you fail to show for an unconfirmed appointment.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

NAME_____

(Please print)

SIGNATURE: _____**DATE:** _____

Laura Gramse, R.D.H., D.M.D.
2194 Wilbraham Road
Springfield, MA 01129

FINANCIAL AGREEMENT

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NAME_____

(Please print)

SIGNATURE: _____**DATE:** _____

Dr. Gramse Wants to Get to Know You!

Today's Date _____

Patient Name _____ DOB _____

When I think about coming to the dentist, I feel…

A. Comfortable… No anxiety about the dentist of the procedures.
B. Anxious… Don't want to come but make myself. Seldom comfortable.
C. Fearful… Have stayed away mainly because of fear and avoid unless necessary.
D. *Extremely* Fearful… Cannot cope. Avoid dentist even though my dental health suffers.

I have avoided the dentist because of…

A. Anxiety and fear
B. Past Experience
C. Financial
D. Time
E. Trust
F Other _____

My childhood dental experiences we…

A. Comfortable and pain free
B. Somewhat uncomfortable
C. Painful / Traumatic
D. Did not go to the dentist

As an adult my dental experience have been…

A. Comfortable and pain free
B. Somewhat uncomfortable
C. Painful / Traumatic
D. Not seen at all or very few visits

I have a fear or concern about…

A. Pain / Lack or being numb
B. Needles
C. Losing Control
D. Gagging
E. Losing my teeth
F. Instruments in mouth
G. Drill
H. Embarrassment from lack of care
I. Sterilization
J. Other _____

Things that make me uncomfortable are …

A. Sounds of the drill
B. Lying too far back in the chair
C. Smells of a dental office
D. Waiting / Being anxious
E. Other _____

I like to…

A. Know all the details
B. Be given the bottom-line
C. Be shown pictures / movies
D. Be given pamphlets / brochures
E. Ask questions of doctor and staff about solutions for my pending treatment

My current concern about my teeth and smile is…

_____
_____
_____

Time 2:13 PM | Laura Gramse, RDH, DMD | Date 6/11/2024

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, 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: _____

TIME 02:13 PM DATE 6/11/2024

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:

Gender: ☐ Male ☐ Female ☐ Unknown Marital 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 ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

KIDDIE RIDER

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: