H&M Family Dentistry
New Patient Information page

Personal Information

Patient Name_____ **Email** _____
Address_____City_____State_____Zip _____
Home Phone_____Work Phone_____**Cell Phone** _____
Date of Birth_____Social Security Number_____Sex M F
Employer_____Occupation_____
Marital Status: Minor ◯ Single ◯ Married ◯
Spouse/Parent or Guardian Name_____Phone_____
Person to Contact in Case of Emergency_____Phone _____
****How did you hear about our office?** _____

Responsible Party Information (Who is in charge of paying your bill?)

Name of Responsible Party_____Relationship to Patient _____
Address_____Phone_____
Date of Birth_____ Social Security Number _____
Employer_____Work Phone _____
Is this person currently a patient at our office? Yes ◯ No ◯

Insurance Information

Name of Insured_____Relationship to Patient _____
Date of Birth_____ Social Security Number _____
Employer_____Phone _____
Address_____City_____State_____Zip Code _____
Insurance Company _____
Group #_____Policy #_____Medicaid #_____
Insurance Address_____City_____State_____ Zip _____

Secondary Insurance Information

Name of Insured_____Relationship to Patient _____
Date of Birth_____Social Security Number _____
Employer_____Phone _____
Address_____City_____State_____Zip Code _____
Insurance Company _____
Group #_____Policy #_____Medicaid #_____
Insurance Address_____City_____State_____Zip _____

I hereby confirm that the information I have provided is accurate to the best of my knowledge. If there are any changes to my information I will inform H & M FAMILY DENTISTRY and update my account.

I consent to the practice contacting me by email and/or phone text messages for the purpose of health promotion, practice news, general follow-ups and appointment reminders.

_____ _____

Signature of patient, parent, or guardian Date

MEDICAL HISTORY INFORMATION

Name of Physician:_____Phone: (_____) _____

Do you have or have ever had any of the following? Please check those that apply:

- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis Artificial Joints*
- ☐ Artificial Heart Valves*
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fever Blister/Cold Sores
- ☐ Frequent Cough
- ☐ Glaucoma
- ☐ Heart Disorder*
- ☐ Heart Infection*
- ☐ Heart Murmur*
- ☐ Heart Pace Maker*
- ☐ Heart Surgery*
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV*/AIDS
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse*
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Surgical Shunt*
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Other_____

* This condition may require antibiotic pre-medication for certain dental procedures.

YES NO

☐ ☐ Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: _____

☐ ☐ Are you now under the care of a physician?
If yes, explain: _____

☐ ☐ Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: _____

☐ ☐ Are you taking any medications or herbals?
If yes, list: _____

Are you allergic to any medications or substances?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Metal ☐ Latex ☐ Other _____

Have you used tobacco? If yes, explain: _____

WOMEN (check): ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

_____ _____

Signature of patient, parent, or guardian Date

DENTAL HEALTH QUESTIONNAIRE

1. When was your last dental visit? _____

2. I have a ☐ **low** ☐ **moderate** ☐ **high** fear of going to the dentist.

3. My mouth and teeth are ☐ **very** ☐ **moderately** ☐ **not** comfortable**.**

4. I am ☐ **very satisfied** ☐ **satisfied** ☐ **dissatisfied** with the appearance of my teeth.

5. I think my present state of dental health is ☐ **excellent** ☐ **good** ☐ **fair** ☐ **poor**.

6. Have you ever been interested in Braces/Invisalign? ☐ **YES NO** ☐

7. Are you interested in a whiter smile? ☐ **YES NO** ☐

8. Are you interested in Dental Implants? ☐ **YES NO** ☐

9. Do you have concerns about wisdom teeth? ☐ **YES NO** ☐

10. Do you snore? ☐ **YES NO** ☐

11. Have you been diagnosed with Sleep Apnea? ☐ **YES NO** ☐

12. Do you have discomfort in your jaws(TMJ) ☐ **YES NO** ☐

13. Do your gums bleed? ☐ **YES NO** ☐

14. Have you ever been told you have gum disease ☐ **YES NO** ☐

15. Are your teeth sensitive to any of the following?

_____Heat_____Cold_____Sweet_____Pressure

16. I would say that my main concerns with my dental health are:

_____

17. Do you require antibiotic medications prior to dental treatment? ☐ YES ☐ NO

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan.

We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.

_____ _____

Signature of patient, parent, or guardian Date

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Broken appointments create scheduling problems for other patients and our practice. If you must change an appointment, please provide us at least **48-hours advanced notification** so that we may use our time to accommodate other patients.

Appointments cancelled with less than 48-hours notice, and missed appointments (no-show), will be subject to a cancellation fee of $50 per hour based on the length of the scheduled appointment.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, **payment in full is due the day of treatment**. If we are submitting claims to insurance the estimated patient portion will be the amount due. For patients that have insurance plans that pay the named insured directly, the full amount will be due at time of service.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, & Discover.
2. We also offer short and long-term financing options. (Interest-free options may apply)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you by your health care professionals.

Finance Charge and Fees

- Balances in excess of 45-days are subject to a finance charge of 1.5% per month (18% annual).
- Returned checks are subject to a $35 accounting fee.
- **An additional 30% of your unpaid balance will be added to your account if it is turned over to a third-party collections agency.**

My signature below acknowledges that I have read, understand, and agree to adhere to the financial policies outlined above. My signature below further acknowledges that my account is my sole responsibility and not dependent on insurance benefits. I have been given the opportunity to ask questions regarding the office financial policy.

Signature of patient, parent, or guardian

Date

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by the Doctor. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information
I authorize my Doctor to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health care professionals.

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to my Doctor.

Photography Release
I authorize the Doctor to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Photographs** to be taken of me and shown to other patients.

_____ _____

Signature of patient, parent or guardian Date

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practices. I understand that I may ask any questions I might have regarding this notice.

Signature _____ Date_____

SUBMIT FORM BY EMAIL