HUNTERS CREEK DENTAL CENTER

WELCOME TO OUR OFFICE

PLEASE PRINT AND THE COMPLETE THE FOLLOWING INFORMATION

NAME _____ CHART# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE# _____ WORK PHONE# _____ CELL PHONE# _____

BIRTH DATE _____ AGE _____ SEX _____ MARTIAL STATUS _____

SOCIAL SECURITY # _____ DRIVERS LICENSE# _____

YOUR OR YOUR PARENT'S EMPLOYER'S _____ OCCUPATION _____

IF YOU ARE A STUDENT, NAME OF SCHOOl/COLLEGE _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE# _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY _____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP _____ EMPLOYER _____ WORK _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ____ YES ___ NO

PLEASE HAVE YOUR INSURANCE CARD(S) AND DRIVERS LICENSE, OR VALID ID READY.

DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ BIRTH DATE _____ SOC. SEC. _____

INSURANCE COMPANY _____ POLICY# _____

INSURANCE PHONE# _____ GROUP# _____

DO YOU HAVE ADDITIONAL INSURANCE? ____YES ___NO

FINANCIAL ARRANGEMENT

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENTS. PLEASE CHECK THE OPTION YOU PREFER. IF YOU HAVE ANY QUESTION PLEASE ASK FOR ASSISTANCE.

PAYMENT IN FULL AT THE TIME SERVICES ARE RENDERED

_____ CASH ___ CHECK ___ CREDIT CARDS ____ INSURANCE

IF YOU CHECKED INSURANCE AS A METHOD OF PAYMENT, PLEASE BE ADVISED IT IS THE PATIENTS/PARENTS RESPONSIBILITY TO FOLLOW-UP ON ALL CLAIMS WITH THE INSURANCE COMPANY.

I ASSUME RESPONSIBILITY FOR ALL FEES AND CHARGES INCLUDING THOSE WHICH ARE NOT COVERED BY MY INSURANCE AND COLLECTION EXPENSE IF I DEFAULT ON MY ACCOUNT. HUNTER'S CREEK DENTAL CENTER POLICY IS TO REQUIRE PAYMENT IN FULL AT THE TIME SERVICES ARE RENDERED.

SIGNATURE _____ DATE _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR)

I GRANT AUTHORITY TO THE DENTIST TO PERFORM TREATMENT AND PROCEDURE INCLUDING EXAM, ANY X-RAYS, AND CLEANING. I WILL BE ADVISED AHEAD OF TIME ANY PROCEDURES THAT NEED TO BE DONE. THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO HUNTER'S CREEK DENTAL BENEFITS OTHERWISE PAYABLE TO ME.

SIGNATURE _____ DATE _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR)

Hunter`s Creek Dental Center

MEDICAL HISTORY

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, 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 you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

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?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

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

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

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 _____ DATE _____

Hunter's Creek Dental Center

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section and sign/date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Collections fees (up to 42% of the full balance)
Legal fees for collection services

_____ _____

Signature of Patient or Guardian Date

_____

Print Name

Hunter's Creek Dental Center

Patient Consent to receive E-mail and/or Telephone Messages

_____

Please Print (Last Name) (First Name)

I agree that the practice may communicate with me electronically at the following address:

_____

E-mail Address *(please print)*

Do we have your permission to:

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y_____ N_____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received/read a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

_____

HIPAA CONSENT

FOR OFFICE USE ONLY

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☞Patient / Parent or Legal Guardian refused to sign form _____ _____

Signature of Office Manager Date

☞Other _____

_____