Hancock Family DENTISTRY

HANCOCK FAMILY DENTISTRY NEW PATIENT FORM

NEW PATIENT INFORMATION

Date _____

Home Phone _____ E-Mail Address _____ Work Phone _____ Cell Phone _____

PERSONAL INFORMATION

Name _____

Address _____

City _____ Zip _____

Birthdate _____ Age _____

Employer _____

Business Address _____

City _____ Zip _____

Position _____

Social Security # _____

SPOUSE / PARENT INFORMATION

Name _____

Employer _____

Business Address _____

City _____ Zip _____

Business Phone _____ Ext _____

Position _____

Social Security # _____

Birthdate _____

WHOM MAY WE THANK FOR REFERRING YOU / HOW DID YOU HEAR ABOUT OUR OFFICE? _____

GENERAL INFORMATION

Convenient appointment time _____

Are you available for appointments on short notice? _____

Person to contact for emergency _____

Relationship to patient _____

Their telephone _____

Nearest Relative Not Living With You _____

Relationship _____ Phone _____

Person responsible for account _____

Address _____

Relationship to patient _____

Employer _____

Driver's License # _____

Social Security # _____

Bank _____ Branch _____

If you have dental insurance, please fill in the following:

PRIMARY CARRIER

Name of Insured _____

Social Security # _____

Insurance carrier name _____

Employer _____

Union or Local # _____

AID or group # _____

Member # _____

Date employed _____

Insurance carrier address _____

SECONDARY CARRIER

Name of insured _____

Social Security # _____

Insurance carrier name _____

Employer _____

Union or Local # _____

AID or group # _____

Member # _____

Date employed _____

Insurance carrier address _____

Dental Medical History Form (Version 8/2015)

Patient Name: _____ Birth Date: _____

Although we primarily treat the area in and around the mouth, one's mouth is a part of the entire body. Previous health problems and/or medication could have an important interrelationship with the dentistry the patient will receive. Please answer each of the following questions as completely as possible. Thank you!

Is the patient under a physician's care now?	O Yes O No	If yes _____
Has the patient ever been hospitalized or had a major operation?	O Yes O No	If yes _____
Has the patient had a serious head or neck injury?	O Yes O No	If yes _____
Is the patient taking medications, pills, or drugs?	O Yes O No	If yes _____
Does the patient take, or have taken, Phen-Fen or Redux?	O Yes O No	If yes _____
Is the patient on a special diet?	O Yes O No	If yes _____
Does the patient use tobacco?	O Yes O No	If yes _____
Please list previous hospitalizations/Surgeries/Serious Illnesses?	O Yes O No	If yes _____

Women: Are You...? O Pregnant/Trying to get pregnant O Nursing O Taking Oral Contraceptives

Is the patient allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic
O Metal O Latex O Local Anesthetics
Other Allergy? O Yes O No If yes _____

Does the patient have or had, any of the following?

ADD/ADHD	O Yes O No	Convulsions	O Yes O No	Heart Pacemaker	O Yes O No	Recent Weight Loss	O Yes O No
AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Heart Trouble/Disease	O Yes O No	Renal Dialysis	O Yes O No
Anaphylaxis	O Yes O No	Diabetes I	O Yes O No	Hemophilia	O Yes O No	Rheumatic Fever	O Yes O No
Anemia	O Yes O No	Diabetes II	O Yes O No	Hepatitis A	O Yes O No	Rheumatism	O Yes O No
Angina	O Yes O No	Down Syndrome	O Yes O No	Hepatitis B or C	O Yes O No	Scarlet Fever	O Yes O No
Anxiety' Disorder	O Yes O No	Drug Addiction	O Yes O No	Herpes	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Easily Winded	O Yes O No	High Blood Pressure	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Emphysema	O Yes O No	High Cholesterol	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint	O Yes O No	*Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Special Needs/ Developmental Delay	O Yes O No
Asperger's	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Autism	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Kidney Problems	O Yes O No	Stroke	O Yes O No
Blood Disease	O Yes O No	Fetal Alcohol Syndrome	O Yes O No	Leukemia	O Yes O No	Swelling of Limbs	O Yes O No
Blood Transfusion	O Yes O No	Frequent Cough	O Yes O No	Liver Disease	O Yes O No	Thyroid Disease	O Yes O No
Breathing Problems	O Yes O No	Frequent Diarrhea	O Yes O No	Low Blood Pressure	O Yes O No	Tonsillitis	O Yes O No
Bruise Easily	O Yes O No	Frequent Headaches	O Yes O No	Lung Disease	O Yes O No	Tuberculosis	O Yes O No
Cancer	O Yes O No	Genital Herpes	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tumors or Growths	O Yes O No
Chemotherapy	O Yes O No	Glaucoma	O Yes O No	Pain in Jaw Joints	O Yes O No	Ulcers	O Yes O No
Chest Pains	O Yes O No	Hay Fever	O Yes O No	Parathyroid Disease	O Yes O No	Venereal Disease	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Attack/Failure	O Yes O No	Psychiatric Care	O Yes O No	Yellow Jaundice	O Yes O No
Congenital Heart Disorder	O Yes O No	*Heart Murmur	O Yes O No	Radiation Treatments	O Yes O No		

*If Heart Murmur, does the patient require antibiotics prior to dental treatment?	O Yes O No	If yes _____
*If Epilepsy or Seizures, date of last seizure?	O Yes O No	If yes _____
Has the patient ever had any serious illness or condition not listed above?	O Yes O No	If yes _____

Does the patient have any of the following habits?

O Sucking thumb/finger O Suck/Bite Lip O Chew/Bite nails
O Chew hard objects O Grind Teeth O Clench Jaw

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 the patients' health. It is my responsibility to inform the dental office of any changes in the patients' medical status. I also authorize the dental staff to perform the necessary dental services the patient may need.

X_____ _____
Signature of Patient, Parent or Guardian Date

This form has been reviewed with Patient, Parent or Guardian and conditions accurately notated.

X_____ _____
Signature of Providing Dentist Date

HANCOCK FAMILY DENTISTRY

Office Policy

FINANCIAL AGREEMENT

Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

INSURANCE FILING

The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS

I/We hereby assign directly to Hancock Family Dentistry, dental insurance benefits otherwise payable to me/us. I/We hereby authorize the release of any information relating to any claims. I/We understand I/We are financially responsible for charges not paid by this assignment.

_____

Responsible Party Signature

DELINQUENT ACCOUNTS

All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS

Failed appointments (less than 24 hours notice) are a significant contributor to rising health care costs. Individuals who fail to show for a confirmed appointment may be assessed a fee based on the length of the missed appointment.

NOTICE OF PRIVACY PRACTICES (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations. Of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

_____

Responsible Party Signature

_____

Today's Date