

Health History & Registration



PATIENT INFORMATION

Name (full legal) _____	Nickname _____	Birth Date _____
(Please Check Your Answer)	Sex: Male Female	Marital Status: Single Married Separated Divorced Widowed
Mailing Address _____	City _____	Zip Code _____
EMAIL: _____	Home # _____	Cell# _____
Employer: _____	Work Number: _____	
Social Security Number _____	Who can we thank for referring you? _____	
In case of emergency, who should be notified?		
1) Name _____	Phone _____	2) Name _____
		Phone _____
Names of family members who are patients here: _____		

PERSON RESPONSIBLE FOR THIS ACCOUNT

(If patient is a child, please complete the next 2 sections for the child's parents)

Name _____	Relationship to Patient _____	Birth Date _____
Home Address (if different from above) _____	Home Phone _____	
Employer _____	Social Security # _____	
Business Address _____	Work Phone _____	

PATIENT'S SPOUSE OR OTHER PARENT

Name _____	Relationship to Patient _____	Birth Date _____
Home Address (if different from above) _____	Home Phone _____	
Employer _____	Social Security # _____	
Work Phone _____		

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Dental Insurance _____ Yes _____ No _____	Dental Insurance _____ Yes _____ No _____
Effective Date _____	Effective Date _____
Subscriber's Name _____	Subscriber's Name _____
Subscriber's Birth Date _____	Subscriber's Birth Date _____
Employer _____	Employer _____
Insurance Co. _____	Insurance Co. _____
Subscriber ID# _____	Subscriber ID# _____
Group No. _____	Group No. _____

We are glad to assist you in securing payment of dental claims from your insurance company; however, benefits must be assigned to us. If your company requires their own claim form, you must bring that form at each visit.

I understand that I am financially responsible for all charges incurred, including those outstanding with the insurance company (if not paid in a timely manner).

If the account becomes a past due and is referred to an attorney for collection, I agree to pay an attorney 33.3% attorney fees and or court costs. If I default on payment of this account, entire balance shall be due at the discretion of the creditor.

Date _____ Signature _____

Patient NAME: _____ **MEDICAL HISTORY**

Name of Your Physician _____ Phone _____ Date of last physical _____

PREMEDICATION PRIOR TO DENTAL CLEANING/PROCEDURES? _____ YES _____ NO

Are you taking any MEDICATION now (PRESCRIPTION AND/OR OVER-THE-COUNTER)? _____ YES _____ NO

If yes, please list _____

Are you pregnant? YES NO Do you take hormones? YES NO Do you take birth control pills? YES NO

Do you have a history of any of the following (please circle yes or no)?

RHEUMATIC HEART DISEASE	YES	NO	LIVER DISEASE	YES	NO	STOMACH OR INTESTINAL ILLNESS	YES	NO
RHEUMATIC FEVER	YES	NO	TESTED HIV POSITIVE/AIDS	YES	NO	ULCER	YES	NO
HEART MURMUR	YES	NO	ANEMIA	YES	NO	CANCER	YES	NO
OPEN HEART SURGERY	YES	NO	SICKLE CELL ANEMIA	YES	NO	NERVOUS OR PSYCHIATRIC CARE	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	LEUKEMIA	YES	NO	SEIZURES	YES	NO
HEART ATTACK	YES	NO	ANY BLEEDING PROBLEMS	YES	NO	SKIN DISEASE		
PACE MAKER	YES	NO	THYROID DISEASE	YES	NO	COLD SORES/FEVER BLISTERS	YES	NO
STROKE	YES	NO	DIABETES	YES	NO	GENITAL HERPES	YES	NO
HIGH BLOOD PRESSURE	YES	NO	KIDNEY DISORDERS	YES	NO	FREQUENT HEADACHES	YES	NO
LOW BLOOD PRESSURE	YES	NO	TUBERCULOSIS	YES	NO	ANY CHRONIC	YES	NO
ANY JOINT REPLACEMENT	YES	NO	EMPHYSEMA	YES	NO	INFLAMMATORY DISEASE		
ARTHRITIS	YES	NO	ASTHMA	YES	NO	I.E. LUPUS		
HEPATITIS	YES	NO	OSTEOPOROSIS	YES	NO			

DO YOU HAVE A HISTORY OF ALLERGIES TO THE FOLLOWING?

MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER) YES NO IF YES, PLEASE LIST:

LOCAL ANESTHESIA YES NO _____

OTHER (FOODS, RESPIRATORY, FLUORIDE, LATEX) YES NO _____

ADDITIONAL INFORMATION ABOUT YOUR HEALTH: _____

DENTAL HISTORY

LAST DENTAL CLEANING APPROX: _____ 6 mos. _____ 1-2 yrs. _____ 5+yrs _____ 10+ yrs.

X-RAYS last taken _____ 6 mos. _____ 1 yr. Dental concerns:

MEDICAL/DENTAL UPDATES

I have read my MEDICAL HISTORY DATED _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	Patient Signature
_____	_____ NONE <input type="checkbox"/>	_____
_____	_____ NONE <input type="checkbox"/>	_____
_____	_____ NONE <input type="checkbox"/>	_____



Lifetime Guarantee

Our guarantee is unique among all dentists in the state of Virginia, and provides you with the peace of mind that comes from knowing we honor our commitments in writing. We want to spell out the specifics so you can view them freely and realize there are no gimmicks. Our chief desire is to foster lifelong relationships, and Dr. Hawkins believes the best way to do that is to prove his loyalty to you by standing behind his dentistry.

The guarantee applies to recommended fillings, permanent crowns, bridges and veneers. It protects you against breakage, de-bonding (becoming loose or falling out), and even decaying under the restoration! The work performed is guaranteed, but the entire tooth is not. For instance, if you have a small filling that does not compromise the integrity of the tooth, and you later break the tooth such that it needs a crown, the procedure is not covered. Likewise, if you have a filling on one surface of the tooth and later develop decay on a different surface of that same tooth, that is not covered as fillings are coded based on the surface involved. If you are eligible for the guarantee, Dr. Hawkins will repair or replace the restoration free of charge for the rest of his career (estimated to be 25 years as of 2010).

In order to maintain the guarantee, only three conditions apply:

1. First, all decay you have must be removed within six months of its diagnosis in order to maintain the guarantee on any completed work. Decay easily spreads from tooth to tooth, so your path to optimal health requires a continual and comprehensive approach to ensure success.
2. Second, you must return for your recommended hygiene visits (usually 6 months) within a 30-day grace period. This allows us to detect small problems before they progress to larger ones. If you are diagnosed with new decay during a hygiene visit, the same rule applies as stated above.
3. Third, if Dr. Hawkins recommends an occlusal guard/night guard to protect the work due to noted wear patterns or a clenching/grinding habit, the patient must obtain it from Dr. Hawkins.

Only work performed by Dr. Hawkins is eligible for the guarantee and any replacements or repairs must be performed by him.

Patient signature: _____ Date: _____

HIPPA CONSENT FORM

Health Insurance Portability and Accountability Act of 1996

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose Personal Health Information (PHI) about you. You have the right to review our NPP before signing this consent. As provided in our NPP the terms may change, in accordance with federal regulations. A current copy may be obtained at our office.

You have the right to request that we restrict how PHI about you is used or disclosed. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this consent form, you consent to our use and disclosure of PHI about you for consultations and/or treatment including surgical procedures and payment. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent. If you have any questions, do not hesitate to contact the office at 804-897-9800.

_____	____/____/____
PATIENT NAME (Please print)	DATE OF BIRTH
_____	____/____/____
Signature of Patient or Guardian	Date of Service

HIPPA RELEASE of INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

<input type="checkbox"/> Spouse _____	(____) _____ - _____
<input type="checkbox"/> Child(ren) _____	(____) _____ - _____
<input type="checkbox"/> Other _____	(____) _____ - _____
<input type="checkbox"/> Information is not to be released to anyone.	

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please Call

My home: _____
 My work: _____
 My cell: _____

If you are unable to reach me:

You may leave a detailed message
 Please leave a message asking me to return your call
 Do not leave a message

_____	____/____/____
Signature of Patient	Date of Service

FINANCIAL POLICY

Thank you for choosing Hawkins Family Dentistry! For your convenience we offer several options of payment: cash, check, debit or credit card (Visa, MasterCard, Discover). We also have companies willing to finance dental treatment if necessary. Payment is due in full at the time of service.

Insurance

We require copayments at the time of service. We will bill your insurance company as a courtesy to you. In order for us to properly file your claims, we must have the most up-to-date information regarding your insurance coverage. It is your responsibility to provide us with this information and notify us of any changes. We cannot guarantee that the insurance will pay, and it is up to you to pay whatever the insurance does not cover.

Initial: _____

Missed Appointments

We are committed to superior service with the latest in technology, done in a timely fashion. We ask that if you need to cancel an appointment that you give us at least 24 hours notice or a cancellation fee of \$50.00 may be incurred.

Initial: _____

Returned Checks

In the event that a check is returned for insufficient funds, a \$35 returned check fee will be added to your account.

Initial: _____

Collection Fees

I understand that I am financially responsible for all charges incurred, including those outstanding with the insurance company. If the account becomes past due and is referred to an attorney for collection, I agree to pay a 33.3% attorney fee and/or court costs. If I default on payment of this account, the entire balance shall be due at the discretion of the creditor.

Initial: _____

I have read the above Financial Policies and I understand and agree to them.

Signature of Patient and/or Responsible Party

Date