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

Dental Insurance_______Yes______No Effective Date______________

Subscriber's Name ______________ Subscriber's Birth Date __________

Employer ______________________________

Insurance Co.______________________________

Subscriber ID#______________________________

Group No.______________________________

SECONDARY INSURANCE

Dental Insurance_______Yes______No Effective Date______________

Subscriber's Name ______________ Subscriber's Birth Date __________

Employer ______________________________

Insurance Co.______________________________

Subscriber ID#______________________________

Group No. ______________________________

We are glad to assist you in securing payment of dental claims from your insurance company; however, benefits must 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 □	____________________________
__________	______________________________NONE □	____________________________
__________	______________________________NONE □	____________________________

____

Authorization for Release of Protected Health Information

Name of Patient: ____ **Date of Birth:** __________________________

The office of Hawkins Family Dentistry is authorized to release protected health information as described below for the identified

Entity to Receive Information. Check each person or class of persons that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐**Voice Messages on** ______________________ **number.**	☐**Appointment Reminders** ☐**Lab Results** ☐**Other**
☐**Spouse or Significant Other:** ________________________________	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** ________________________________	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** ________________________________	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Photo of patient received by patient or legal guardian** ☐**Photo taken by staff (Example: pre/post procedure)**	☐**May be posted in office** ☐**May be posted on website** ☐**Other:** _______________

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing.

____Date ____________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

FINANCIAL POLICY

Payment

Thank you for choosing Hawkins Family Dentistry. Full Payment is due at the time of service. If insurance benefits apply, estimated co-payments and deductible are due at the time of service. We strive to respect your time and ask for the same courtesy which is why for all appointments over one hour in length we require a 50% deposit of the required copay at the time of scheduling. For your convenience we offer several options of payment: cash, check or credit card (Visa, Mastercard or Discover). We also offer Care Credit.

Initial:_________

Insurance

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will file with your insurance company as a courtesy to you. We work very hard to obtain your benefits to provide accurate treatment estimates however, it is very hard for us to have knowledge and keep track of every aspect of your insurance. It is up to you to have knowledge of your benefits. If you have any questions concerning the treatment estimates or questions about your insurance coverages, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. It is also your responsibility to provide us with any information and notify us of any changes. We cannot guarantee your 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 $100.00 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

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address:____
____
____

I have received a copy of the Notice of Privacy Practices for the above named practice.

________________________________ ______________________
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  ____
- ❑ Other:____
  ____

Prepared By ____________________________________

Signature ____________________________________

Date ____________________________________