

Hambright Family Dental Care

Today's Date _____ * Please present your Driver's License and all Insurance Cards *

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Age _____
Address _____ Social Security # _____
City _____ State _____ Zip _____ ___ Single ___ Married ___ Divorced ___ Widowed
Home Phone _____ Email _____
Cell Phone _____ Text ___ Yes ___ No
Work Phone _____ How did you hear about our office? Circle One
Friends/Family Facebook Drove By Mail Brochure Insurance
Other _____

RESPONSIBLE PARTY Preferred Payment Method _____

Name _____ Date of Birth _____
Address _____ Social Security # _____
City _____ State _____ Zip _____ ___ Single ___ Married ___ Divorced ___ Widowed
Home Phone _____ Email _____
Cell Phone _____ Text ___ Yes ___ No
Work Phone _____ Relationship to Patient _____



PRIMARY INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____
Employer _____ Social Security # _____
Insurance Company _____ Subscriber ID # _____
Relationship to Patient _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____
Employer _____ Social Security # _____
Insurance Company _____ Subscriber ID # _____
Relationship to Patient _____ Group # _____

Today's Date _____

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth _____ Age _____

Emergency Contact _____ Hm. Phone _____ Cell _____

Name of nearest relative NOT living with you _____ Phone _____

Do you have or have you ever had any of the following: Please check Yes or No

<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Bone Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Muscular Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Paralysis
<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain - Angina	<input type="checkbox"/> Y <input type="checkbox"/> N Pins, Plates, Screws, Rods	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy / Convulsion
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting
<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N STD / HIV / AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Steroids	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice
<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol
<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Tobacco
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Thinners	<input type="checkbox"/> Y <input type="checkbox"/> N Illicit Drugs
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Transfusions	<input type="checkbox"/> Y <input type="checkbox"/> N Serious Injuries

ALLERGIC TO ☐ Latex ☐ Penicillin/Amoxicillin ☐ Other _____

WOMEN ONLY Are You Pregnant? YES NO Are You Nursing? YES NO

HAVE YOU TAKEN Fosamax, Actonel, Boniva, or Reclast? YES / NO

PRIMARY HEALTH CARE PHYSICIAN _____ Phone # _____

MEDICATION LIST	Drug / Dosage	Prescribing Physician	Taken For
Preferred Pharmacy	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Phone Number	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.

I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider, who may release such information to you.

Signed _____ Date _____

Hambright Family Dental Care

At Hambright Family Dental Care, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

* Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefits plans will never pay for the completion of your dental care. It is only meant to assist you.

* We currently accept many private care insurance plans. This means that we work with literally hundreds of companies. Although we can maintain computerized histories of payment given by a company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out-of-pocket figures you may require.

* We bill your insurance as a courtesy. If your insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. In the event collection action has to be taken regarding this account, the undersigned agrees to pay legal fees and court cost incurred by Hambright Family Dental Care in collecting this account. Ultimately, you are responsible for all charges incurred in our office.

* Hambright Family Dental Care does require payment in full, for your portion, at the time of service. We accept most major credit cards, cash, and personal checks. We also work with CareCredit, a commercial creditor. We offer a 6 Months No Interest Plan as well as a revolving line of credit designed to meet your treatment plan needs with approved credit. You may apply online at www.carecredit.com. Returned checks will result in a fee of **\$30 per check**.

* A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments and to be on time. If you must change your appointment, we ask that you do so with a 24 hour notice. No notice and No shows can result in a **\$25 per hour fee per patient**.

I agree with the above conditions: Signed _____ Date _____
Patient / Parent / Legal Guardian

HEALTH INFORMATION PRIVACY PROTECTION ACT (HIPPA)

Federal law requires physicians and health care providers to obtain written consent before disclosing your personal health information with other health care professionals or facilities. Please know that complete confidentiality is a priority of the highest magnitude in our office. However, in the course of providing optimal care for you, it may be necessary to disclose diagnoses or lab results to other physicians or facilities directly related to your care. A copy of this policy is posted in our office and on our web site.

A hard copy is available at your request.

I understand my HIPPA rights: Signed _____ Date _____
Patient / Parent / Legal Guardian