Patient Information **Today's Date:** ____

First Name: ______________________________**MI:** _______**Last Name:** ______________________________**Preferred Name:** ________________________________

Home Address: ____ **City:** __________________________________ **State:** _______________ **Zip:** ___________________

Home #: ____ **Work #:** ____ **Mobile #:** ____

Email: ____**SSN:** ____ **Driver's License No.** ________________________________

Sex: M / F **Birth Date:** ________ /_______ /__________

Family Status (circle): **Single** **Married** **Widowed** **Divorced** **Child**
Spouse's Name: ____

Have you been a patient in this practice: Y / N **Name of General Dentist:** ____

How did you first hear about our office? (Circle one): Internet search Insurance Dentist: ____

Friend / Family member: ____Other: ____

Employer's Name: ____Employer's Address: ____

Person Responsible for Account
☒ Self (if self, skip this section) ☒ Spouse ☒ Father ☒ Mother ☒Guarantor ☒ Step Father ☒Step Mother ☒ Other

Name of responsible party: ____Birth Date: _______/_______/________
SS#:____________________________________

Home Address: ____City: _________________________________State: __________Zip: __________________

Home #: ____Work #: ____Mobile #: ____

Email: ____Relationship to patient (Circle): Self Spouse Parent Other: _______________________

Emergency Contact Information

In the event of an emergency, whom should we contact?

Name: ____

Relationship: ___________________________Home #:______________________________Work #:____________________________Mobile#:______________________________

Primary Dental Insurance Company

Name of Insured: ____Relationship to patient: ____

Insured Birth Date: ________/________ /_________ Insured SSN: ____

Insurance Plan Name: ____Insurance Co Phone #: ____

Group #: ______________________________________ ID #: ____

Claims Address: ____City:___________________________State: _________ Zip: _________________________

Primary Medical Insurance Company

Name of Insured: ____Relationship to patient: ____

Insured Birth Date: ________/___________ /________ Insured SSN: ____

Insurance Plan Name: ____Insurance Co Phone #:____

Group #: ____ID #: __________________________________

Claims Address: ____City:___________________________ State: _________ Zip: _________________________

Medical History

Patient Name: ____ Date of Birth: ______________________________________

1. Date of last physical exam: ___________________________
2. Physician's Name:____________________________________Physician's Phone#:____

2. Have you been hospitalized in the past 5 years (if yes, explain below)? Yes No

____

3. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, what for?

____

4. Have you ever had any excessive bleeding requiring special treatment? Yes No

5. Women: Are you pregnant / trying to get pregnant / breast feeding? Yes No Delivery date: _____________________

6. Are you allergic to or have you had an ALLERGIC REACTION to any of the following (please circle if yes):

Local Anesthetic Penicillin Codeine Other

Latex Acrylic Metals

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax Actonel Boniva Warfarin / Coumadin Pradaxa Xarelto

Aredia Reclast Zometa Eliquis Plavix / Effient / Aspirin / Ticlid

8. Please list other medications you are taking:

____

____

____

Have you had, or do you currently have:	Yes	No	Notes
Damaged heart valves			
High Blood Pressure			
High cholesterol			
Low Blood Pressure			

Have you had or do you currently have:	Yes	No	Notes
Convulsions / epilepsy			
Stroke			
Thyroid trouble			
Diabetes			

Chest pain / Angina				Low Blood Sugar			
Heart Attacks				Kidney trouble			
Irregular Heart Beat				Are you on dialysis?			
Cardiac pacemaker				Arthritis / joint disease			
Heart Surgery				Osteoporosis Osteopenia			
Pneumonia, bronchitis, chronic cough				Osteonecrosis			
Asthma				Stomach ulcers, acid reflux, GERD			
Hay fever / Sinus problems				Contagious diseases			
Snoring / Sleep apnea				Sexually transmitted diseases			
Difficult breathing / Lung problems				HIV / AIDS			
Emphysema / COPD				Problems with immune system			
Do you smoke? How many packs/day?				Steroid treatment			
Do you use smokeless tobacco				Delay in healing			
Blood transfusion				Cancer / Tumor / Growth			
Bleeding disorder / Anemia / Sickle Cell				Chemotherapy / Radiation treatment			
Bleeding tendency / abnormal bleeding				Chronic fatigue			
Hepatitis, liver disease				History of Drug abuse?			
Gallbladder problems				History of Alcohol abuse?			
Fainting spells				Eye disease / Glaucoma			
Jaw pain				Mental Health issues			

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Patient Signature: ____
Date____

We make every effort to keep down the cost of your care. An estimate of the charges associated with procedures will be provided to you. Patients are required to satisfy any known co-payments in full at the time of treatment. Failure to collect any co-payments at the time of treatment does not constitute a waiver of this office to seek payment in the future. All fee quoted are only good for 60 days.

Each Patient is financially responsible for his or her own account unless the Patient is a minor, then both parents are responsible. Your insurance is a contract between you, your employer and the insurance company. WE are not a party to that contract and any issues arising from this are the sole responsibility of the Patient and the insurance company. All employees of Hampton Oral & Facial Surgery shall be held harmless for any inaccuracy or omission of information provided to this office by the Patient's insurance carrier.

Patients without insurance are required to pay the day treatment is preformed unless other arrangements are agreed to in writing. All accounts must be paid in full within 60 days of the settlement of your insurance claim. We charge a $35.00 fee for any returned checks, regardless of reason.

I understand that I am responsible for treatment and payment of all services. If a minor is being treated, I certify I have the authority to authorize treatment of said minor(s), that I have the authority to submit the insurance provided and I

further understand the individuals(s) who are the insurance carriers are also responsible for said treatment and payment in accordance to our terms.

I understand should my account be assigned to collections for non-payment, I agree to pay all costs, including collection agency fees (not to exceed 33.33%), Court costs, attorney fees (not to exceed 25%), interest at 10% from the date of delinquency and any other costs associated with the enforcement of said collection.

We reserve the right to charge for any appointments cancelled or broken without at least 24 hour prior notice. Emergencies may be taken into consideration. I agree to all the terms and conditions of this agreement and my signature below indicates that I have read and fully understand this agreement.

____

Signature of Responsible Party Date

____

Printed Name of Responsible Party Social Security Number

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me and understand that by signing this form I am giving consent to your use and disclosure of my protected health information to the following:

Person name:
____Relationship:________________________

Address:
____

Signature:
____Date:_______________________

I acknowledge the staff of this office may access information contained in the Prescription Monitoring Program on all Schedule II, III or IV prescriptions dispensed to a patient. (Initials) ____________________