



**Patient Information**

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ APT# \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

Email: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M / F Family Status (circle): Single Married Widowed Divorced Child

Name of General Dentist: \_\_\_\_\_ Employer's Name \_\_\_\_\_

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

Name of Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

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 Prolia 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			
Chest pain / Angina			
Heart Attacks			
Irregular Heart Beat			
Cardiac pacemaker			
Heart Surgery			
Pneumonia, bronchitis, chronic cough			
Asthma			
Hay fever / Sinus problems			
Snoring / Sleep apnea			
Difficult breathing / Lung problems			
Emphysema / COPD			
Do you smoke? How many packs/day?			
Do you use smokeless tobacco			
Blood transfusion			
Bleeding disorder / Anemia / Sickle Cell			
Bleeding tendency / abnormal bleeding			
Hepatitis, liver disease			
Gallbladder problems			
Fainting spells			
Jaw pain			

Have you had or do you currently have:	Yes	No	Notes
Convulsions / epilepsy			
Stroke			
Thyroid trouble			
Diabetes			
Low Blood Sugar			
Kidney trouble			
Are you on dialysis?			
Arthritis / joint disease			
Osteoporosis Osteopenia			
Osteonecrosis			
Stomach ulcers, acid reflux, GERD			
Contagious diseases			
Sexually transmitted diseases			
HIV / AIDS			
Problems with immune system			
Steroid treatment			
Delay in healing			
Cancer / Tumor / Growth			
Chemotherapy / Radiation treatment			
Chronic fatigue			
History of Drug abuse?			
History of Alcohol abuse?			
Eye disease / Glaucoma			
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.**

**X** 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 fees 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.

**X** \_\_\_\_\_  
Signature of Responsible Party Date

**X** \_\_\_\_\_  
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: \_\_\_\_\_

**X** 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) \_\_\_\_\_**