PATIENT REGISTRATION

Patient Name _____ **Sex M ☐ F ☐ Preferred Name/Nickname** _____
Patient's Address _____ **Home Phone** _____
City _____ **State** _____ **Zip Code** _____ **Work Phone** _____
Age _____ **Birthdate** _____ **Cell Phone** _____
☐Single ☐Married ☐Widowed ☐ Separated ☐ Divorced **Email**_____
Patient SS # _____ **Occupation** _____ **Employer** _____
Name of Spouse _____ **Birthdate** _____ **SS#** _____
Occupation _____ **Spouse's Employer** _____
Referred to Office by _____

****

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name _____ **Relationship to you** _____
Address and Phone Number of Emergency Contact Person _____

Who is responsible for this account? _____ **Relationship to patient** _____

****

Insurance Company _____ **Group #** _____
Is patient covered by additional insurance? ☐yes ☐no Subscriber's name _____
Subscriber's Birthdate _____ **Subscriber's SS#** _____ **Relationship to Patient** _____

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ **and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

_____ _____ _____
Responsible Party Signature **Relationship** **Date**

****

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ **City/State** _____
Date of last dental visit _____ **Date of last dental X-rays** _____
Please check Yes or No to indicate if you have had any of the following:

Bad breath	**☐ Yes ☐ No**	**Bleeding gums**	**☐ Yes ☐ No**	**Blisters on lips or mouth**	**☐ Yes ☐ No**
Burning sensation on tongue	**☐ Yes ☐ No**	**Chew on one side of mouth**	**☐ Yes ☐ No**	**Tobacco Habit**	**☐ Yes ☐ No**
Clicking or popping Jaw	**☐ Yes ☐ No**	**Dry mouth**	**☐ Yes ☐ No**	**Fingernail biting**	**☐ Yes ☐ No**
Do you or have you ever experienced pain/discomfort in your jaw joint	**☐ Yes ☐ No**	**Food collection between teeth**	**☐ Yes ☐ No**	**Grinding teeth**	**☐ Yes ☐ No**
Food collection	**☐ Yes ☐ No**	**Lip or cheek biting**	**☐ Yes ☐ No**	**Orthodontic treatment**	**☐ Yes ☐ No**
Periodontal Treatment	**☐ Yes ☐ No**	**Jaw pain or tiredness**	**☐ Yes ☐ No**	**Gums swollen or tender**	**☐ Yes ☐ No**
Loose teeth or Broken fillings	**☐ Yes ☐ No**	**Mouth breathing**	**☐ Yes ☐ No**	**Sensitivity when biting**	**☐ Yes ☐ No**
Pain around ear	**☐ Yes ☐ No**	**Sensitivity to cold**	**☐ Yes ☐ No**	**Have you ever had a serious or difficult problem associated with previous dental work**	**☐ Yes ☐ No**
		Sensitivity to sweets	**☐ Yes ☐ No**	**Type of bristles**	**☐Hard ☐Medium ☐Soft**
		Sores or growths in your mouth	**☐ Yes ☐ No**	**Sensitivity to heat**	**☐ Yes ☐ No**

MEDICAL HISTORY

Physician's Name _____ **Date of last visit** _____

Please check yes or no to indicate if you have had any of the following:

AIDS	□ Yes □ No	**Fainting or dizziness**	□ Yes □ No	**Psychiatric Care**	□ Yes □ No
Alzheimer's	□ Yes □ No	**Glaucoma**	□ Yes □ No	**Radiation Treatment**	□ Yes □ No
Anemia	□ Yes □ No	**Headaches**	□ Yes □ No	**Respiratory problems**	□ Yes □ No
Anxiety	□ Yes □ No	**Head injuries**	□ Yes □ No	**Rheumatic Fever**	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	**Heart Murmur**	□ Yes □ No	**Scarlet Fever**	□ Yes □ No
		Heart problems	□ Yes □ No	**Serious accident**	□ Yes □ No
Artificial Heart valves	□ Yes □ No	**Hepatitis Type:** _____	□ Yes □ No	**Shortness of breath**	□ Yes □ No
				Sickle Cell Anemia	□ Yes □ No
Asthma	□ Yes □ No	**Hemophilia**	□ Yes □ No	**Sinus trouble**	□ Yes □ No
Back Problems	□ Yes □ No	**Herpes / Cold Sores**	□ Yes □ No	**Skin rash**	□ Yes □ No
Bleeding abnormally (with extractions or surgery)	□ Yes □ No	**High Blood Pressure**	□ Yes □ No	**Special Diet**	□ Yes □ No
		HIV Positive	□ Yes □ No	**Stroke**	□ Yes □ No
Blood Disease	□ Yes □ No	**Hypoglycemia**	□ Yes □ No	**Swelling of feet / ankles**	□ Yes □ No
Cancer	□ Yes □ No	**Jaundice**	□ Yes □ No	**Swollen neck glands**	□ Yes □ No
Chemotherapy	□ Yes □ No	**Jaw pain**	□ Yes □ No	**Thyroid problems**	□ Yes □ No
Circulatory problems	□ Yes □ No	**Joint Replacement**	□ Yes □ No	**Tonsillitis**	□ Yes □ No
		Kidney Disease	□ Yes □ No	**Tuberculosis**	□ Yes □ No
Congenital Heart Lesions	□ Yes □ No	**Liver Disease**	□ Yes □ No	**Tumor or growth on head or neck**	□ Yes □ No
Cortisone Treatments	□ Yes □ No	**Low Blood Pressure**	□ Yes □ No		
Cough, persistent or bloody	□ Yes □ No	**Mitral Valve Prolapse**	□ Yes □ No	**Ulcer**	□ Yes □ No
		Nervous problems	□ Yes □ No	**Venereal Disease**	□ Yes □ No
Depression	□ Yes □ No	**Pacemaker**	□ Yes □ No	**Any hospital stays?**	□ Yes □ No
Diabetes	□ Yes □ No	**Women:**		**Explain:** _____	
Do you wear Contact lenses?	□ Yes □ No	**Are you Pregnant?**	□ Yes □ No	_____	
		Due Date: _____		_____	
Epilepsy	□ Yes □ No	**Are you nursing?**	□ Yes □ No	_____	
Emphysema	□ Yes □ No	**Are you taking birth control pills?**	□ Yes □ No	_____	

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MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

_____

_____

_____

ALLERGIES

☐ **Amoxicillin**	☐ **Latex**
☐ **Aspirin**	☐ **Local Anesthetic**
☐ **Barbiturates (sleeping pills)**	☐ **Penicillin**
☐ **Codeine**	☐ **Sulfa**
☐ **Erythro**	☐ **Other** _____
☐ **Iodine**	_____

Has your Physician ever advised you to take antibiotics prior to dental appointments? □ Yes □ No

Pharmacy Name _____
Phone _____

I understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's Signature **Date**

Hammond Dental Care Financial Policy

- We will estimate your insurance co-payment at the time of your appointment and require that payment of that amount at the time services are rendered.
- As a courtesy, we will only submit to a primary insurance for you. **Filing a claim with your secondary insurance will be your responsibility**.
- **It is expressly understood that dental insurance is a benefit to the patient and not the dental office. The patient or responsible party is responsible for all charges in the event the insurance company fails to pay for any reason.**
- **All charges are your responsibility from the date services are rendered. If after 30 days from filing your claim, we have not received payment, we will ask that you pay the remaining balance, and discuss your claim with your insurance carrier.**
- All statements will go out on a monthly basis, regardless if all insurance claims have been paid or not. It is your responsibility to ensure that your insurance carrier has received a claim for all services rendered to you and paid to the provider in a timely manner.
- A late charge may be assessed if your minimum payment is not received by the due date. The amount of the late charge will be .05% of the past due amount.
- A finance charge is imposed on those charges not paid in full within 60 days of the date you were first billed. The finance charge is a minimum of 1.5% of the balance due per month.
- There will be a returned check fee of $25. Your account will also be subject to additional collection fees and finance charges.
- A $35 fee will be assessed for any "**no show"** appointment.
- I/We understand and agree to pay court costs, attorney fees and a 50% (fifty percent) collection fee on any outstanding balances over 30 days past due. I/We also agree to pay 2% interest per month on any outstanding balances over 30 days past due.

I _____, have read, understand and agree to the above policy. I understand that I am fully responsible for the fees due for services rendered, regardless of any insurance I may have.

Signature_____

Date:_____

HAMMOND
DENTAL CARE

Smile Questionaire

	Yes	No
1. Are you satisfied with the appearance of your teeth?	☐	☐
2. Are you happy with the color of your teeth?	☐	☐
3. Do you want whiter teeth?	☐	☐
4. Do you want straighter teeth?	☐	☐
5. Do you have any gaps that you do not like?	☐	☐
6. Are there any old fillings that you don't like looking at?	☐	☐
7. Do you have any tooth-colored fillings that don't match your teeth?	☐	☐
8. Do you often get food trapped between your teeth?	☐	☐
9. What would you like to change the most about the appearance of your teeth?	☐	☐

_____

_____

_____

10. Do you have concerns over what the end result might look like that have been a factor in you not having cosmetic dentistry done?	☐	☐
11. Do you have concerns over fees that have prevented you from taking advantage of some of the available options to enhance your smile?	☐	☐

Please indicate which information you would like on any following procedures:

- ☐ Teeth Whitening
- ☐ Implants
- ☐ White Fillings
- ☐ Treatment for Anxious Patients
- ☐ Porcelain Veneers or Crowns
- ☐ Dentures Retained on Implants
- ☐ Invisible Braces
- ☐ Interest Free Finance for Treatment

Hammond Dental Care
16936 W. Bell Rd. #201
Surprise, AZ 85374
Hammonddentalcare.net

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my right to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ***Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.***
- ***Obtain payment from third-party payers for my healthcare service; and***
- ***Conduct normal healthcare operations such as quality assessment and improvement activities.***

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the use and disclosures of my protected health information.

I have been given the right to review and receive a copy of such Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Hammond Dental Care restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that Hammond Dental Care is not required to agree to my requested restrictions, but if Hammond Dental Care does agree then they are bound to abide by such restrictions.

Patient Name _____

Signature _____

Relationship to Patient _____ Date _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, therefore, please review carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. The act gives you significant new rights to understand and control how your health information is used, HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information:

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives, or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to you protected health information, which you can exercise by presenting a written request to the privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect, copy and amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of January 1, 2010, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. **We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services Office, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.**