

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 _____.
I understand that I am financially responsible for all charges whether or not insurance is involved and that any outstanding balances on my account will be my responsibility. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also 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 _____
Reason for leaving _____

Please check Yes or No to indicate if you have had any of the following:

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

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

_____</p> |
|--|--|---|

MEDICATIONS

Please list medications you are currently taking:

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Erythro | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> 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: _____



Smile Questionnaire

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

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? Yes No
11. Do you have concerns over fees that have prevented you from taking advantage of some of the available options to enhance your smile? Yes No

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

- | | |
|---|--|
| <input type="checkbox"/> Teeth Whitening | <input type="checkbox"/> Porcelain Veneers or Crowns |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Dentures Retained on Implants |
| <input type="checkbox"/> White Fillings | <input type="checkbox"/> Invisible Braces |
| <input type="checkbox"/> Treatment for Anxious Patients | <input type="checkbox"/> 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.**