



Welcome

HAMPDEN FAMILY DENTISTRY, P.A.

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS #/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Patient's Sex F M

Name _____ Birthday _____ Home Phone _____

Address _____ City _____ State/Prov _____ Zip/P.C. _____

Email _____ Cell Phone _____

*Denotes Primary Insurance Company name _____

Member ID number _____

Name of Employer issuing policy _____

Name of policy holder if not yourself _____ Policy Holders date of birth _____

Do you prefer to receive calls at your: Home Work Cell Phone

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank For Referring You? _____

Person To Contact in Case of Emergency? _____

Hampden Family Dentistry, P.A.

Office Policies, Oct 18 2017

Patient Care

We will provide the highest quality comprehensive dental care with special attention given to your individual needs. We require that all children under the age of 18yrs be accompanied by a parent or legal guardian; if special arrangements have not been made with office staff , treatment cannot be provided for these patients. Every effort will be made to ensure your comfort.

Emergencies

We will make every effort to treat dental emergencies of our established patients promptly and minimize discomfort. If you have dental pain after hours please go to your local emergency room

For You Protection

Our practice meets all prescribed government standards of sterilization and infection control.

Insurance

Most dental insurance plans cover some but not all of the cost of your treatment. Co-payment and deductible expenses are the responsibility of the patient and must be paid at the time of service or upon receipt of the bill. If payment problems arise we will require you to pay for your visits each time you come into our office and we will submit your insurance as a courtesy for you. We gladly accept a family's primary insurance, only, and request that patients submit for reimbursement by their secondary insurance when applicable.

Payment Choices

We make every effort to minimize the cost of your care. You can help by being prepared to meet co-payments after every dental visit. For your convenience, we accept VISA, MasterCard, and Discover cards, and personal checks and cash. We give senior discounts and discounts and for cash or check payment same day of service for non insured individuals

Cancellations

To ensure timely care for all our patients, we request at least 24 hours notice if you cannot keep your scheduled appointments. There will be a \$35.00 charge for failed appointments. If three appointments are missed without the required notification, we will request that the patient seek care at another dental office.

Billing

If it is necessary for us to bill you, please pay promptly to avoid rebilling fees. If you have a question regarding your insurance benefits and their payment for dental services, we ask that you contact them directly as they are equipped and better informed to handle your concerns. Our office staff cannot speak on behalf of your insurance carrier. Accounts over 90 days are automatically sent to a collection agency to service these delinquent accounts.

All of our policies are designed so that our office staff can provide quality and affordable dental care for you and your family.

I have read and understand the above office policies and agree to them.

Signature _____

Date _____

Patient Name:

Eaglesoft Medical History(Copy)(Copy)(Copy)

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

What is the name of your primary care physician?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs? Please list all medications	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you use tobacco products? How much? What type?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet? Please tell us what type and your restrictions	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have City water or Well Water?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you think you have cavities or gum disease?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Women: Are you...

 Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following and what type of reaction did you have?

 Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Recent Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A,B,C	<input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No
Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No	Anemia	<input type="radio"/> Yes <input type="radio"/> No	Angina	<input type="radio"/> Yes <input type="radio"/> No	Treatment for High/Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No
Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Recent Shingles	<input type="radio"/> Yes <input type="radio"/> No	Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No	Blood Disease	<input type="radio"/> Yes <input type="radio"/> No
Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No
Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Lung/Respiratory Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Acid Relux/GERD	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No
Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Mental Health Condition	<input type="radio"/> Yes <input type="radio"/> No	Chrohns	<input type="radio"/> Yes <input type="radio"/> No	Diabetes Type I, II	<input type="radio"/> Yes <input type="radio"/> No
Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No	Frequent Mouth Sores	<input type="radio"/> Yes <input type="radio"/> No	Chemo Therapy	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed

 Yes No

If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

HAMPDEN FAMILY DENTISTRY

I have read and/or received a copy of this office's Notice of Privacy Practices.

* You May Refuse to Sign This Acknowledgment*

Print Name of Patient _____

Signature: _____ Date: _____

Authorization Form for Use or Disclosure of Patient Information

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

The following person(s) may receive this patient information:

Entire dental record

Information limited to the following: _____

Do not share my information with any other person other than what was in the Notice of Privacy Practices

Specific description of the patient information to be used or disclosed if it is limited:

Purpose(s) of this use or disclosure: Treatment, payment, dental care operations

I AUTHORIZE THE FOLLOWING PERSON(S) TO MAKE THIS USE OR DISCLOSURE:

Hampden Family Dentistry Employees

This authorization expires on the following date, or when the following event occurs:

Does not expire Expires on ____/____/____

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient

_____ Date _____

Parent or Personal Representative ONLY: Relationship _____

Print:Name: _____ signature _____ DATE: _____