Patient Information

Patient Name: _____ Date: *01/31/2025*
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
☐ _____
_____
_____
_____

- List all active medications: _____
  _____
  _____

- Have you ever had any complications following dental treatment?
  ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital, needed emergency care, or had major surgeries during the past two years?
  ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a primary care or specialist physician?
  ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Smile Questionnaire:

Do you have any current concerns or factors you would like to discuss about your current smile?

☐ Bite Alignment ☐ Chipped/Missing Tooth ☐ Crooked Teeth ☐ Jaw Clenching/Grinding Teeth

☐ Staining/Discoloration ☐ Sensitive/Bleeding Gums ☐ Other _____

Next Page for Insurance and Consents

Spouse or Financial Responsible Party Information

The following is for "Head of House" billing information. This will be who statements will be addressed to in the case that there are balances on the accounts:
☐ the patient's spouse ☐ the patient's parent or guardian ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary Dental

Insurance Plan Name:_____

Name of Subscriber: _____ Is Subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Claims Mailing Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Dental

Insurance Plan Name:_____

Name of Subscriber: _____ Is Subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Claims Mailing Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

HIPAA ACKNOWLEDGMENT

By signing below, I understand that:

*I have the right to revoke or cancel this authorization at any time by providing notice in writing to this office.
*If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my protected information that has already occurred.
*Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.
*I have a right to inspect or copy the protected health information that will be used or disclosed as per this authorization.
*I am not required to sign this authorization. **I understand that by not signing this agreement, this office will be unable to file any and all insurance claims.**

Other than your Insurance Company, who may we disclose your dental and or medical information to:

_____

_____

Signature of patient, parent or guardian: _____ Date: _____

Financial Policy

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We accept assignment of insurance benefits as a courtesy for a period of 60 days. You should contact your insurance carrier regarding any unpaid claim. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days. Be advised with all returned checks we impose a fee of $30.00, which can change. A delinquent account creates an uncomfortable environment for everyone.

Insurance companies change their benefits without notice to you or our office, so this is only an **estimate**. We will file your claims and assist in any way we can to increase the speed of payment from your insurance company. Insurance companies pay a percentage of treatment rendered based on the type of treatment. The portion of treatment not covered by your insurance company is considered "your portion," and it is payable by you at the time of service.
If your Insurance Company pays you directly, the full cost of treatment will be due at the time of service.
***We are not In-Network with Anthem Blue Cross Blue Sheild, Delta Dental, or Envolve. Patients with this insurance may be subject to higher fees or be required to pay in full and file on their own behalf.**

We schedule visits by appointments only. Please help us to stay on schedule by arriving for your appointment on time. If you are more than 15 minutes late for your appointment, we will ask you to reschedule and you may be charged a broken appointment fee.

If it becomes necessary to cancel an appointment, we request to be notified a minimum of 2 business days before the time of the appointment. This allows us to schedule conveniently for the patient filling the cancellation.
No cancelation will be accepted via voice message, email, or text message without this 2-business days' notice.
Patients breaking or canceling appointments without this 2-business days' notice are subject to be charged as follows:
$50.00 for each hour you have reserved with Dr. Hammond or the hygienist.

I have read the above and agree to this content. Once I am informed of the treatment plan and associated fees, I agree to be responsible for all charges for dental services not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with any claim filed.

_____ Date: _____
Signature of patient, parent or guardian
I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist dental entity.