PATIENT INFORMATION

Last Name: ______________________________

First Name: ______________________ Middle Initial: ______ Today's Date: ______________

Preferred Name: ______________________________

Date of Birth: ____/____/____ Gender*: __________ Phone: (   ) ______-________

Address: ______________________________

City: ______________________ State: __________ Zip: ______________

Email: ______________________ Additional Contact Info: ______________

Preferred contact method(s): ☐ *Phone* ☐ *Text* ☐ *Email*

**If your gender is different than the sex assigned at birth, and we are filing insurance, please let the front desk know.*

DENTAL INSURANCE INFORMATION

Please fill out the following for the policy holder:

Name: ______________________ Date of Birth: ____/____/____

Social Security Number: ____-____-____ Employer: ______________________

Insurance Company: ______________________ Member ID: ______________________

ADDITIONAL CONTACT INFORMATION

Whom else may we discuss medical/account information with?

Name: ______________________ Phone Number: (   ) ______-________

RECORDS RELEASE

I give my permission for Hunter Family Dentistry to leave messages regarding my dental care and account information. This consent will remain valid unless revoked in writing.

Signature: ______________________ Date: ______________

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

- You, the patient, have the right to accept or reject dental treatment recommended by your dental provider.
- Prior to treatment, carefully discuss the benefits and risks of the recommended procedure, alternative treatments, or the option of no treatment with your dental provider.
- Only consent to treatment after you discussed potential benefits, risks, and complications with your dental provider, and all of your questions are answered.
- By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications.
- It is very important that you provide your dentist with accurate information regarding your medical health history.
- It is very important that you follow your dental provider's advice and recommendations regarding medication, pre/post-treatment instruction, referrals to specialists, and follow-up appointments.
- If you fail to follow the advice of your dental provider, you may increase the chances of a poor outcome.
- Different dental procedures come with different types of risk. Please discuss with your dental provider the specific risks associated with your treatment.
- At your request, your dental provider can provide you with a list of common and severe risks associated with your specific procedures.

CONSENT TO TREATMENT

Your dental provider will design a treatment plan in which he/she will recommend that you undergo specific dental procedures. You will be presented with the optimum treatment for your particular dental needs. If, in the dentist's judgment, other acceptable treatment options exist, these will be discussed with you as well. There are likely to be increased risks and potential complications should you elect to have an alternative form of treatment that differs from the optimum treatment plan presented to you. Please discuss these issues in more detail with your dentist. Be sure to understand the potential risks and complications before consenting to treatment.

I have read, understood, and accepted each statement listed above.

Patient ____________________ Date ________

Parent/Guardian ____________________ Date ________

HEALTH HISTORY

PATIENT NAME ______________________________ Birth Date ____ - ____ - ____

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
Other If yes, please explain: ____________________

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Genital Herpes	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
									Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____________________

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 ____________________ DATE ____________

FINANCIAL POLICY

Regarding Payment

- **We accept the following form of payment: Cash, Check, Major Credit Cards and Care Credit.**
- **Payment for service is due at the time of service.**
- **Returned checks are subject to a $30.00 fee.**
- **Please Note: We request 24 hours notice to cancel appointments to avoid our cancellation fee.**

Regarding Insurance

- We are happy to file with your insurance company on your behalf.
- Not all treatment is covered by insurance. You are responsible for knowing the dental procedures and costs your insurance will cover.
- Our relationship with your insurance company is subject to change. Please check with our front desk regarding our in/out of network status with your provider before your appointment.
- You are responsible for your portion of the treatment fee regardless of our estimate of your dental benefit. We will do everything possible to determine an accurate estimate of your coverage. However, we will not know the actual breakdown until we receive payment from your insurance company.
- We do not accept any secondary plans, workman's compensation insurance, or accidental medical insurance.
- If your insurance is terminated for any reason, you will be solely responsible for all the treatment costs at the time of service.

____
Patient Date

____
Parent/Guardian Date

HIPPA ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY
“Acknowledgement”

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

____
Patient (Please Print)

____
Patient Signature   Date

OR

____
Signature of Personal Representative   Date

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent   ☐ Guardian   ☐ Power of Attorney   ☐ Other

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ An emergency prevented us from obtaining acknowledgement.

☐ A communication barrier prevented us from obtaining acknowledgement.

☐ The individual was unwilling to sign.

☐ Other: ______________________________________

____
Staff Signature   Date

INFORMATION REGARDING BISPHOSPHONATES

Bisphosphonates are a class of drugs that are used to treat osteoporosis in women. Stronger forms of bisphosphonates are sometimes used in the treatment of certain cancers, as well as for a disorder called Paget's disease.

A connection has been made between bisphosphonate type drugs and a serious bone disease called Osteonecrosis of the Jaw. The United States Food and Drug Association, along with the manufacturer of one of these drugs (Fosamax) issued a warning to health care professionals on this issue on September 24th, 2004.

It is very important for you to let us know if you are now, or have ever taken in the past, ANY type of bisphosphonate class drug. If we treat you without knowing if you are now taking, or have taken in the past. any of these drugs, your health could be seriously affected. These drugs continue to affect the body for years after they are no longer being taken, so we must know if you have ever taken any of them. Brand names of these drugs include (but may not be limited to) are:

Fosamax	**Boniva**
Zometa	**Bonefos**
Aredia	**Skelid**
Actonel	**Didronel**

Are you now, or have you In the past, taken a bisphosphonate drug, including any of the brands above?

☐ NO ☐ YES IF YES, DATE TAKEN ____________________

Patient ____________________ Date

Parent/Guardian ____________________ Date