PATIENT INFORMATION

Name ____ Sex: M F

Address ____

City ____ State ____________ Zip Code _________________

Best Telephone# ____________________________ Can receive text messages ☐ YES ☐ NO

Birthdate ___________________________________ Social Security # _______________________________

Occupation __________________________________ Employer ____________________________________

Marital Status ______________________________ Spouse or Guardian ______________________________

Reason for the visit __________ ____

Who may we thank for referring you?

____

Emergency Contact: ________________________ Relationship ___________ Telephone# _________________

FINANCIAL INFORMATION

DENTAL INSURANCE (Primary)

Insured's Name ___________________________ Birthdate ______________ Relationship ________________

Insured's Social Security # _________________________________ Insurance ID# _______________________

Insured's Employer _______________________________________ Group # ____________________________

Insurance Company _______________________________________ Insurance Telephone# ________________

Insurance Company Address ____

DENTAL INSURANCE (Secondary)

Insured's Name _____________________________ Birthdate __________ Relationship ___________________

Insured's Social Security # _________________________________ Insurance ID# _______________________

Insured's Employer _______________________________________ Group # ____________________________

Insurance Company _______________________________________ Insurance Telephone# ________________

Insurance Company Address ____

We ask that you realize we do not work for an insurance company. Rather, we work 100% for our patients. We feel insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. It is your responsibility to know your individual coverage. You are

responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company. Not between the insurance company and your dentist. Payment, copays and deductibles are required at the time of service. If for any reason insurance does not pay, payment will be expected from the patient. A returned check fee of $50 will be assessed on all returned checks. Delinquent accounts will be assessed all collection, legal and administrative costs to the fullest extent of the law.

I accept and understand the patient's responsibilities outlined above.

Signature ____ Date _____________________

MEDICAL HISTORY *Please circle any of the following that you have had or presently have*

Heart Attack	Heart Murmur	Allergies or Hives	Nervousness
Heart Failure	Scarlet Fever	Hay Fever	Psychiatric Treatment
Heart Disease	Rheumatic Fever	Asthma	Epilepsy or Seizures
High Blood Pressure	Artificial Heart Valve	Emphysema	Fainting or Dizzy Spells
Angina Pectoris	Mitral Valve Prolapse	Cough	Drug Addiction
Heart Pacemaker	Congenital Heart Lesions	Tuberculosis (TB)	Ulcers
Blood Transfusion	Artificial Joints (Hip, Knee)	AIDS	Fever Blisters
Stroke	Rheumatism	HIV Positive	Cold Sores
Anemia	Arthritis	Liver Disease	Bruise Easily
Hemophilia	Kidney Disease	Hepatitis A	Phen-Fen Treatment
Diabetes	Thyroid Disease	Hepatitis B	Cosmetic Surgery
Sickle Cell Disease	Sinus Trouble	Hepatitis C	Venereal Disease
Heart Surgery	Cortisone Medication	Yellow Jaundice	Glaucoma

Food Allergies? If yes, what type? ____

Cancer? If yes, what type? ______________________________ Did you receive Radiation or Chemotherapy? (Circle)

Are you allergic or have you reacted adversely to any of the following? (Circle all that apply)

	Sleeping Pills	Darvon	Latex
Penicillin/Amoxicillin	Local Anesthetic	Codeine	Other Antibiotics
Erythromycin	Novocain/Xylocaine	Demerol	
Tetracycline	Scopolamine	Valium	
Percodan	Aspirin	Nitrous Oxide	

Other drugs or medications? ____

Are you taking or using medication for: (Circle those that apply)

Diabetes (Pills/Shots)	Stomach Trouble	Thyroid
Nerves	Headaches/Migraines	Hormones (Including Birth Control)
Sleeping Trouble	Arthritis	Allergies
High Blood Pressure	Periodontal Disease	
Heart Disease	Blood Thinners (Anticoagulants)	
Blood (Liver/Iron Pills)	Seizures (Dilantin)	

Please list ALL Medications you are currently taking (including over the counter, vitamins, minerals & herbal supplements)

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____

Are you taking or have you previously taken Bisphosphonates? ☐ **YES** ☐ **NO**

These include: Fosamax Aredia Didronel Zometa Skelid Actonel Bonefos Boniva

Have you been a patient in a hospital during the past two years? If yes, what for? ____	YES	NO
Do you use: Cigars Cigarettes Pipe Marijuana Tobacco Chew Vaping (Circle) If yes, do you currently use them? ______________ How Frequently? ________________ How many packs/day? ___________	YES	NO
Following injuries, have you ever had bleeding problems?	YES	NO
Do injuries/cuts take longer to heal now than previously?	YES	NO
Have you recently lost weight unintentionally?	YES	NO
Is there a history of diabetes in your family?	YES	NO
Do you urinate more than 6 times a day?	YES	NO
Are you currently pregnant?	YES	NO
Are you currently on a doctor prescribed diet? If yes, for what reason? ______________________	YES	NO
Have you been treated for alcoholism or chemical dependency?	YES	NO

Physician's Name ____ Telephone# _________________________

Physician's Address ____ Last Medical Exam ____________________

DENTAL HISTORY

Date of last dental visit _________________________________ Date of last dental cleaning ___________________________

Dentist Name ____ Dentist Telephone# _________________________________

Dentist Address ____

Do you require premedication prior to dental visit?____

What is your most important dental concern you would like addressed? _____________________________________

____

Are you having pain or discomfort currently? YES NO
Have you come to our office for relief from pain? YES NO
If yes, have you been in pain for more than 3 weeks? YES NO
If yes, where is the pain? ____
Do you have unreplaced missing teeth? YES NO
If yes, why have you not replaced them? ____
Do you have difficulty swallowing? YES NO
Do your gums bleed when brushing your teeth? YES NO
Have you been told you have periodontal disease? YES NO
Is any part of your mouth sensitive to temperature or pressure? YES NO
If yes, where? ____
Does food catch between your teeth? YES NO
If yes, where? ____
Have you had any serious trouble associated with previous dental treatment? YES NO
If yes, briefly describe ____
Do you have any pain or soreness around the eyes or ears? YES NO
Do you have any unpleasant taste or odor in your mouth? YES NO
Do you ever get cold sores or canker sores? YES NO
Do you ever feel that you have a dry mouth? YES NO
Are you dissatisfied with your teeth or their appearance? YES NO
Does it seem you always have something to be treated when you visit a dentist? YES NO
In the past, have you required a lot of dental work? YES NO
Have you ever had a bad experience in the dental office? YES NO
If yes, briefly describe ____
How do you feel about going to the dentist? (Circle the best answer) No Problem Apprehensive Scared

OCCLUSAL SCREENING

How do you feel about your teeth? ____

Do you wear complete and/or partial dentures? YES NO
If yes, upper, lower or both? ____
If yes, how long have you worn dentures? ____
If yes, are you unhappy with your dentures YES NO
Would you like to know more about permanent replacements? YES NO
Have you had any Periodontal (gum) treatments? YES NO
Have you worn braces on your teeth (orthodontics)? YES NO
Are you aware of any problems with snoring? YES NO
Would you like your smile to look better or different? YES NO
Have you ever been diagnosed with sleep apnea? YES NO
Have you ever been diagnosed with TMJ/TMD? YES NO
Do you have discolored teeth that bother you? YES NO
Do you regularly use dental floss? YES NO
Do you wear a bite splint/night guard? If yes, how frequently? ______________________________ YES NO
Are you aware of grinding or clenching your teeth? YES NO
Are you unhappy with the appearance of your teeth? YES NO
Do you have chronic headaches, earaches or neck pains? YES NO
Have you ever experienced an inability to move your jaw or open widely? YES NO
Which side of your mouth do you chew on? (Circle) Right Left Both

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to Hometown Dental otherwise payable to me for the services as described, realizing that I am responsible to pay for non-covered services.

Signature ____ Date ___________________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Hometown Dental to release any information relating to my treatment for insurance purposes, including radiographs, clinical notes and study models.

Signature ____ Date ___________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Hometown Dental has given you a copy of its' Privacy Notice, which explains how your health information will be handled in various situations.
Check all that are true:
[ ] I have received a Hometown Dental Privacy Notice.
[ ] Hometown Dental has given me the chance to discuss my concerns and questions about the privacy of my health information.
[ ] I wish to place the following restrictions on the use and/or disclosure of my personal health information:

____

____

Signature ____ Date ___________________

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent. I understand I am responsible for payment of services at the time they are rendered.

I hereby authorize the Hometown Dental team to take photographs, slides, intraoral photographs and/or videos of my face, jaws, and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, videotapes, DVDs television), and professional publications (dental magazines and journals). I further understand that if photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs and materials.

Signature ____ Date ____________________

NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information when necessary. Please review it carefully. Hometown Dental, we are committed to treating information about you and your health responsibility. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protective health information. This notice is effective December 13, 2021, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record and Information

Each time you visit Hometown Dental a record of your visit is made. Typically, this record contains your symptoms, examination, diagnoses, treatment, lab results and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

➢A basis for planning your care and treatment
➢A means of communication among many health professionals who contribute to your care
➢A legal document describing the care you received
➢A means by which you a third party payer can verify that services were actually provided to obtain payment for services
➢A tool in educating health professionals
➢A source of data for medical research
➢A source of information for public health officials
➢A source of data for our planning and marketing
➢A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Hometown Dental, the information belongs to you. You have the right to:

➢Inspect and copy your health record
➢Amend your health record
➢Obtain an accounting of disclosures of your health information
➢Request communications of your health information by alternative means or at alternative locations
➢Request a restriction on certain uses and disclosures of your information
➢Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Hometown Dental is required to

➢Maintain the privacy of your health information
➢Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
➢Abide by the terms of this notice
➢Notify you if we are unable to agree to a requested restriction
➢Accommodate reasonable requests you may have to communicate health information by alternative means or at alternate locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue use or disclose your health information after we have received a written

revocation of the authorization according to the procedures included in the authorization. For more information or to Report a Problem. If you have any questions and would like additional information, you may contact our office Hometown Dental 1250 Byron Road Howell MI 48843 (517) 546-3330.