Hamilton Mill Dental Center

Personalized care to create optimal health

Patient Information

Patient Name _____ Nickname _____ Date of Birth _____

(First, Last, Middle Initial)

Address: Street _____ City _____ State _____ Zip _____

Email _____ Cell # _____ Home # _____ Work # _____

Sex: M ___ F___ SSN/Patient ID# _____ Single ____ Married ____ Widowed ____ Divorced ____ Minor _____

Who is responsible for this account? _____ Relationship to patient _____

Patient's Employer/School Name: _____Occupation _____

Spouse's Name _____ Birthdate _____ Spouse's Employer _____

Whom may we thank for referring you? _____

If Patient is a Minor:

Mother's Name/Address: _____ Phone # _____

Father's Name/Address: _____ Phone # _____

Insurance Information

Insurance Company: _____ ID # _____ Group # _____ PH # _____

Subscriber's Name _____ Birthday _____ SS # _____

Employer _____ Relationship to Patient _____

Is the patient covered by additional insurance? Y ___ N ___ If yes, Insurance Co. _____

Subscriber's Name _____ Birthday _____ SS # _____

Employer _____ Relationship to Patient _____

Assignment and Release of Insurance Information:

I certify that I, and/or my dependent(s), have insurance coverage with the above listed insurance company and assign directly to Hamilton Mill Dental Center LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges unpaid by insurance. I hereby authorize the use of my signature on all insurance submissions.

Hamilton Mill Dental Center LLC may use my health care information and may disclose such information to the above-named insurance company (ies) for the purpose of obtaining payment for services rendered and for determining my insurance benefits or the benefits payable for related services.

Print name of Patient or Guardian _____ Relationship to Patient _____

Signature of Patient or Guardian _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Physician Name/Specialty _____Recent Visit _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. Hospitalization for illness or injury _____ ☐ ☐
2. An allergic reaction to:
   - ☐ none known
   - ☐ latex
   - ☐ antibiotics (if yes, which one(s)? _____ _____)
   - ☐ metals (if yes, which one(s)? _____)
   - ☐ other _____
3. Heart problems, or cardiac stent within the last 6 months_____ ☐ ☐
4. Artificial heart valve, repaired heart defect (PFO) _____ ☐ ☐
5. Pacemaker or implantable defibrillator _____ ☐ ☐
6. History of bacterial endocarditis _____ ☐ ☐
7. Diabetes (hbA1c=___) _____ ☐ ☐
8. Artificial Joint, Prosthesis _____ Date _____ ☐ ☐
9. High cholesterol or taking statin drugs _____ ☐ ☐
10. High or low blood pressure (circle the one that applies) _____ ☐ ☐
11. A stroke _____ ☐ ☐
12. Anemia or blood disorder _____ ☐ ☐
13. Rheumatic or scarlet fever _____ ☐ ☐
14. Emphysema, shortness of breath, sarcoidosis _____ ☐ ☐
15. Tuberculosis _____ ☐ ☐
16. Chicken pox, measles (circle the one that applies) _____ ☐ ☐
17. Asthma or breathing problems (circle the one that applies) _____ ☐ ☐
18. Sleep problems (i.e. sleep apnea, snoring) _____ ☐ ☐
19. Sinus problems _____ ☐ ☐
20. Kidney disease _____ ☐ ☐
21. Liver disease _____ ☐ ☐
22. Prostate disorder _____ ☐ ☐
23. Thyroid, parathyroid disease (circle one that applies) _____ ☐ ☐
24. Calcium deficiency _____ ☐ ☐
25. Hormone deficiency _____ ☐ ☐
26. Digestive disorders (i.e. celiac disease, gastric reflux) _____ ☐ ☐
27. Stomach or duodenal ulcer _____ ☐ ☐
28. Arthritis, rheumatoid arthritis, lupus_____ ☐ ☐
29. Osteoporosis/osteopenia (circle the one that applies) _ ☐ ☐
30. Contact lenses_____ ☐ ☐
31. Glaucoma_____ ☐ ☐
32. Dementia_____ ☐ ☐
33. Head or neck injuries_____ ☐ ☐
34. Epilepsy, convulsions (seizure)_____ ☐ ☐
35. Neurologic disorders_____ ☐ ☐
36. ADD/ADHD (circle the one that applies) _____ ☐ ☐
37. Viral infections, cold sores (circle the one that applies) _ ☐ ☐
38. Lumps or swelling in the mouth_____ ☐ ☐
39. Hives, skin rash, hay fever (circle the one that applies) _ ☐ ☐
40. STI/STD_____ ☐ ☐
41. Hepatitis (type _____) ☐ ☐
42. HIV/AIDS _____ ☐ ☐
43. Cancer (type_____) ☐ ☐
44. Radiation therapy _____ ☐ ☐
45. Chemotherapy, immunosuppressive _____ ☐ ☐
46. Tumor, abnormal growth _____ ☐ ☐
47. Psychiatric treatment_____ ☐ ☐
48. History of depression_____ ☐ ☐
49. Emotional problems_____ ☐ ☐
50. Alcohol /street drug use (circle the one that applies) __ ☐ ☐
51. Other Condition (_____) _____ ☐ ☐

ARE YOU: YES NO

52. Presently being treated for any other illness _____ ☐ ☐
    if yes _____ ☐ ☐
53. Aware of a change in your health in the last 24 hours __ ☐ ☐
    if yes circle (fever, chills, new cough, diarrhea) _____ ☐ ☐
54. Taking dietary supplements _____ ☐ ☐
55. Taking medication for weight management(fen-phen) _ ☐ ☐
56. A tobacco user or previous tobacco user _____ ☐ ☐
57. Experiencing frequent headaches _____ ☐ ☐
58. Hypersensitive to sounds, smells tastes or touch _____ ☐ ☐
59. Taking birth control pills _____ ☐ ☐
60. Pregnant _____ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen injections _____

List all medications, supplements, and or vitamins that you are currently taking and purpose you are taking them for

Drug	Purpose	Drug	Purpose

Please Advise us in the future of any change in your medical history or any medications you may be taking.

Patient's Signature _____ **Date** _____

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Previous Dentist _____ How long have you been a patient there _____

Date of your most recent treatment (other than a cleaning) ____ /____ /_____

What is your estimate of your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10 (most) (____) _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed/ _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury) or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25. Are your teeth crowded or developing spaces? _____	☐	☐
26. Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
28. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
30. Do you wear, or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
32. Have you ever whitened (bleached) your teeth? _____	☐	☐
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	☐	☐
34. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient / Responsible Party Signature _____ **Date** _____

Dr. Jeremy R. Ward Dr. Uyen Maschek

OFFICE POLICIES

Insurance Policy

As a courtesy to our patients, we are happy to file your dental insurance and help you maximize your dental benefits. **Please know that you will be using your out of network benefits as we are not on any provider lists or plans**. We obtain as much benefit information as we can prior to your appointment, however, it is an agreement between you and the insurance company. Any deductibles and percentages not paid by the insurance are due at the time of treatment. Please keep in mind that you are responsible for any balance after the insurance pays should your insurance benefits pay less than estimated. We will make every effort to work with you regarding any unpaid balance. However, once a balance reaches 90 days past due, we will have no choice but to seek outside collection options.

Appointments

If you are unable to keep your appointment for any reason, please contact us **24 hours** prior to your appointment. This will allow us to offer the appointment time to someone else. **We understand there may be emergencies that arise, but if appointments are missed or broken without sufficient notice, a fee of $60.00 will be charged to your account.** You will be personally responsible for this charge. Future appointments will not be scheduled until this fee is paid.

If you arrive late to your appointment, please note the appointment may need to be rescheduled.

Student Status Updates

If you or a dependent child is over 18 years of age and a **full-time student,** you must keep your student status updated with your insurance company in order for the insurance to pay on your claim. Insurance requires this update each time the semesters change. We ask that you keep this information current so as not to delay claim payment.

_____

Print Patient Name

_____ _____

Patient / Responsible Party Signature **Date**

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Authorization to Release Information to Family Members/ Significant Others

By Signing below, I give my permission to **Hamilton Mill Dental Center LLC.** to share complete health records including, but not limited to, diagnoses, lab test results, treatment, scheduling information, and billing records for all conditions regarding _____ with the person(s) I have specified below. **(print patient name)**

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Signature of **Patient (or) Responsible Party**: _____ **Date**: _____

You may update this authorization at any time by contacting the office.

Acknowledgement of receipt of notice of privacy practices

* You may refuse to sign this acknowledgment section

By Signing below, I am stating that I have read a copy of this office's Notice of Privacy Practice for _____.

(print patient name)

Signature of **Patient (or) Responsible Party**: _____ **Date**: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign.

____ Communications barriers prohibited obtaining acknowledgement.

____ An emergency situation prevented us from obtaining acknowledgement.

____ Other (Please Specify) _____