PATRICK HUNTER
Family Dentistry

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____ Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____ Subscriber ID # _____

Insurance Company _____ Phone_____

Employer_____ Group Name_____ Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____ Subscriber ID # _____

Insurance Company _____ Phone_____

Employer_____ Group Name_____ Group #_____

Comments:

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

[ ] None_____

_____

_____

_____

_____

List all the medications or drugs you are allergic to:

[ ] None_____

_____

_____

_____

_____

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen.

[ ] None_____

_____

_____

_____

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit_____ Are you in pain? _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old?_____

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

Signature_____Date_____

If you need more space, you may continue below: