Welcome

Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date:_____

E-mail Address:_____

Name:_____

I prefer to be called:_____ **Male** **Female**

Birthdate:___/___/___ **Age:**___ **SS#**_____

Home Address:_____

_____

Single **Married** **Partnered** **Divorced/Separated**

Hm #: (___)_____ **Cell #:**_____

Wk #: (___)_____ **Ext:** _____

Employer: _____

Employer's Address: _____

_____

How long there?_____ **Occupation:** _____

Whom may we Thank for referring you?_____

Other family members seen by us:_____

Previous/Present Dentist:_____

Person Responsible for Account: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk # (___)_____ **Ext:** ____ **SS#:** _____

Birthdate:___/___/___

Relative or Friend not living with you.

His/Her Name:_____ **Relation:** _____

Wk #:(___)_____ **Hm #: (___)**_____

INSURANCE

Primary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____**Relation:**_____

Insured's Birthdate: ___/___/___ **Insured's ID #:**_____

Insured's Employer: _____

Employer's Address:_____

_____

Do you have Secondary Insurance? **YES** **NO**

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-pay and deductibles that my insurance does not cover. I hereby authorize payment directly to Hagarty Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Continue…….

MEDICAL HISTORY

Do you have a personal physician? YES NO

Physician's Name: _____

Phone #: (___)_____Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphinate? Yes No

Have you ever taken Phen-fen? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems (Please circle)

Abnormal bleeding/Hemophilia
AIDS
Alcohol/Drug Abuse
Anemia
Arthritis
Artificial Bones/ Joints/ Valves
Asthma
Blood Transfusion
Cancer/ Chemotherapy
Colitis
Congenital Heart Defect
Diabetes
Difficulty Breathing
Fever
Emphysema
Epilepsy
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack/ Surgery
Heart Murmur
Hepatitis
Herpes/ Fever Blisters
High Blood Pressure
HIV
Hospitalized for Any Reason
Kidney Problems
Liver Disease
Low Blood Pressure
Lupus
Mitral Valve Prolapse
Pacemaker
Psychiatric Problems
Radiation Treatment
Rheumatic/Scarlet
Seizures
Shingles
Sickle Cell Disease/Traits
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis (TB)
Ulcers
Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following? (Please circle)

Aspirin Erythromycin Penicillin

Codeine Jewelry/Metals Tetracycline

Dental Anesthetics Latex Other

Please list any other drugs/materials that you are allergic to:

_____

_____

Why have you come to the dentist today? _____

_____

Are you currently in pain? Yes No
Do you require antibiotics before dental treatment? Yes No

Your current dental health is: Good Fair Poor

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you floss daily: Yes No Brush daily? Yes No

Have you ever had gum treatment? Yes No

Do your gums ever bleed? Yes No Ever itch? Yes No

Have you ever had periodontal disease? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Are your teeth sensitive to heat, cold or anything else?

_____

Do you have any loose teeth? Yes No

Do you still have wisdom teeth? Yes No

Would you like whiter teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you like to change?

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that 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 staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature Date

Hagarty Family Dental PC

PAYMENT POLICY

Thank you for using us as your dental care provider. We are committed to your treatment being successful. Please understand that the payment of your bill is your responsibility and it is considered part of your treatment. The following is a statement of our payment policy which we require you to read prior to beginning your treatment at our office.

1. All payments are due upon completion of your dental appointment. Co-payments and deductibles are estimates and must be paid when treatment is completed, unless prior arrangements have been made with us. Some services are not completed in one appointment, such as crowns and dentures, in which case your co-pay is due only for treatment completed that day.
2. For patients that have dental insurance, the costs incurred during treatment are the responsibility of the patient. As a courtesy to you, our office will estimate your co-pay and file your claim. However, any difference between our estimate and what your insurance company actually pays will become the **sole responsibility of the patient.** Your insurance is a contract between you and your insurance company, we are not a party to the contract. We can also request a pre-treatment estimate from your insurance company before any treatment is started. Pre-treatment estimates can take approximately 4-6 weeks to process and it is still not a guarantee of payment by your insurance company.
3. We accept most major credit cards, check, and cash as payment.
4. We request that any cancellations be made 48 hrs in advance. Although we know personal emergencies and situations arise, if you do need to cancel an appointment with less than 24 hours notice or do not show up for your appointment more than 3 times in a 12 month period, you may be charged a $75 missed appointment fee before we can schedule your next appointment.

Thank you for understanding our payment policies. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this payment policy.

_____ _____

Patient signature Date

HAGARTY FAMILY DENTAL
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name (please print):_____ **SS#:**_____

SECTION B: TO THE PATIENT/PARENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE ON FILE:

I hearby authorize payment directly to HAGARTY FAMILY DENTAL for the dental benefits otherwise payable to me. I understand that my signature is valid for three years from signed date, unless revoked by me at an earlier date.
HAGARTY FAMILY DENTAL and its staff are authorized to provide any insurance company (s), claim administrator (s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.
This authorization is valid for the term of the coverage of the policy or contract, in force on this day only, or for three years, which ever is shorter.

Signature of Patient or Guardian:

_____. **Date:** _____/_____/_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.