Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. If you have any questions or need any help completing this form, please ask us – we will be happy to help!

PATIENT INFORMATION (CONFIDENTIAL):

Date: _____

Name: _____ Prefer to be called: _____
(First, Middle, Last)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Email Address: _____

Birthdate: _____ Social Security Number: _____-____-_____ ❑ Minor ❑ Single ❑ Married

If Student, Name of School/College: _____ ❑ Full-time ❑ Part-time

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency: _____ Phone: _____

RESPONSIBLE PARTY:

Name of person financially responsible for this account: _____

Relationship to patient: ❑ Self ❑ Parent ❑ Other: _____

Driver License Number: _____ Birthdate: _____

Employer: _____ Employer Phone: (____)_____

INSURANCE INFORMATION:

Name of insured: _____ Relationship to Patient: _____

Insured's Birthdate: _____ Insured's Social Security Number: _____-____-_____

Plan Name (usually the Employer): _____ Group #: _____

Insurance Company: _____ Insurance Phone: (____)_____

Ins. Address: _____City: _____ State: _____ Zip: _____

Our office will gladly create and file your insurance claims for your convenience. We do ***not*** verify specific plan coverage, but will ***estimate*** your benefits based on a "typical" dental insurance plan, or based on the information we have gathered about your specific dental plan. As a courtesy to our patients, we will accept assignment from your ***primary*** insurance company and wait for **30 days** for your insurance to pay your dental insurance claim. You will be expected to pay the difference between the full fee and the insurance ***estimate*** at the time services are rendered unless other financial arrangements are discussed in advance. You will remain responsible for your entire account balance regardless of any insurance coverage or any insurance estimate given to you. If a claim remains unpaid after 30 days, you will receive a statement for the balance due on your account within 15 days, along with copies of the unpaid claim(s) so you may follow up with the insurance company regarding the status of the unpaid claim(s).

⇨ **YOUR BALANCE BECOMES DUE BY YOU IF YOUR INSURANCE HAS NOT PAID WITHIN 30 DAYS.**

I understand and agree to the insurance acceptance guidelines outlined above. I authorize my insurance company to pay Dr. Hinton directly for claims that would otherwise be paid to the subscriber.

_____

Signature – Person Financially Responsible for Account Date

FINANCIAL COMMITMENT:

I understand that the fees for services rendered are due at the time of service unless specific financial arrangements are made in writing in advance. I understand that 18% APR interest may be charged for accounts past due and any collection fees incurred will be paid by me.

FF	MA
L	NPM

_____

Signature – Person Financially Responsible for Account Date

OVER

MEDICAL

Yes ☐ **No** ☐ Are you under a physician's care now? **If Yes, Why?** _____

Physician: _____ **Phone:** _____

Yes ☐ **No** ☐ Have you ever been hospitalized or had any serious illness or injury? **If Yes, Discuss:**

_____

Yes ☐ **No** ☐ Are you taking any medications, pills, drugs, herbs or vitamins? **If Yes, Please list:**

_____

_____

Yes ☐ **No** ☐ Are you allergic to any medications or substances?

If Yes: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metals ☐ Latex

☐ Other(s): _____

Yes ☐ **No** ☐ Do you use tobacco? **If Yes:** ☐ Cigarettes ____ /day ☐ Chew ☐ Dip ☐ Other: _____

Women only: ☐ Pregnant/May Be Pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Do you now have or have you ever had any of the following? (Note: If you answer "Yes" to either of the starred* conditions, please check with us – premedication with antibiotics may be required.)

	Yes	No		Yes	No		Yes	No
Need Premedication?	☐	☐	Drug Addiction/Alcoholism	☐	☐	Kidney Problems	☐	☐
Artificial Heart Valve *	☐	☐	Epilepsy or Seizures	☐	☐	Liver Disease	☐	☐
Artificial Joint *	☐	☐	Excessive Bleeding	☐	☐	Low Blood Pressure	☐	☐
AIDS	☐	☐	Fainting or Dizziness	☐	☐	Lung Disease	☐	☐
Alzheimer's / Dementia	☐	☐	Heart Attack	☐	☐	Mitral Valve Prolapse	☐	☐
Angina / Chest Pain	☐	☐	Heart Disease	☐	☐	Osteoporosis/Bisphosphonates	☐	☐
Anxiety	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐
Arthritis or Rheumatism	☐	☐	Heart Pace Maker	☐	☐	Radiation/Chemo Treatment	☐	☐
Asthma	☐	☐	Hemophilia	☐	☐	Sinus Trouble	☐	☐
Breathing Problem	☐	☐	Hepatitis A (infectious)	☐	☐	Stomach/Intestinal Disease	☐	☐
Bruise Easily	☐	☐	Hepatitis B or C	☐	☐	Stroke	☐	☐
Cancer [type:_____]	☐	☐	Herpes	☐	☐	Thyroid Disease	☐	☐
Cold Sores / Fever Blisters	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
Depression	☐	☐	HIV Positive	☐	☐	Tumors or Growths	☐	☐
Diabetes	☐	☐	Hypoglycemia	☐	☐	Ulcers	☐	☐

Yes ☐ **No** ☐ **Any other medical condition not listed?** _____

DENTAL HISTORY

Yes ☐ **No** ☐ Do your gums bleed while brushing or flossing?
Yes ☐ **No** ☐ Have you ever had periodontal treatment?
Yes ☐ **No** ☐ Are your teeth sensitive to hot or cold or sweets?
Yes ☐ **No** ☐ Do you feel pain in any of your teeth?
Yes ☐ **No** ☐ Do you have any sores in or near your mouth?
Yes ☐ **No** ☐ Do you have frequent headaches?
Yes ☐ **No** ☐ Do you clench or grind your teeth?
Yes ☐ **No** ☐ Do you bite your lips or cheeks frequently?
Yes ☐ **No** ☐ Do you chew ice?
Yes ☐ **No** ☐ Have you ever had orthodontic treatment?

Have you ever experienced any of the following jaw problems?

Popping or Clicking Sound **Yes** ☐ **No** ☐

Pain (joint, ear, side of face) **Yes** ☐ **No** ☐

Difficulty opening or closing **Yes** ☐ **No** ☐

What would you change about your smile?

☐whiter ☐straighter ☐no metal showing ☐close spaces

☐other: _____

How long since your last dental cleaning? _____

How often do you brush? _____ floss? _____

What is your chief dental concern? _____

Is there anything we can do to make your visits with us more comfortable for you? _____

➡ **To the best of my knowledge, all the preceding answers are correct and complete. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.**

Patient Signature: _____ **Date:** _____

Patient Name: _____ Date: _____

⏩ OUR CONFIRMATION AND MISSED APPOINTMENT PROTOCOL:

We value your time and understand you are investing that valuable time in your dental health when you make an appointment with us. We work very hard to schedule effectively so you do not have to wait more than a few minutes to be seen for your appointments. We also maintain a list of patients who are waiting to get in to see us. **Therefore, it is critical that your appointments with us are confirmed AND that we receive at least 2 business days notice if you need to reschedule your appointment.**

We have made it as simple as we can for you to remember and confirm your appointments by providing automated reminders and requests for confirmation through email and/or text. We ask for your return consideration by responding/confirming AND giving us at least 2 business days notice if your appointment date/time is not going to work in your schedule – this gives us time to offer your appointment to another patient waiting to get in. **We may charge a $50 cancellation fee** if we do not receive 2 business days notice and we are unable to fill your appointment.

⇨ **Patient Signature: _____ Date: _____**

⏩ COMMUNICATION PREFERENCES:

So we can continue to provide exceptional service customized for YOU, we would appreciate your feedback on how YOU would prefer to receive communication from us. >>> Please note as you are making your choices below that if we do not receive an appointment confirming response from you via email or text, we will still call you.

How do you prefer that we provide your appointment reminders? (MARK ALL THAT APPLY)

- ❑ Email
- ❑ Text
- ❑ Call Cell Phone
- ❑ Call Work Phone
- ❑ Call Home Phone

How do you want us to provide your billing statements?

- ❑ I won't need statements because I don't have insurance and I will pay in full at each appointment
- ❑ Just charge my Credit Card for any balance remaining after insurance pays and email a receipt to me – please provide your CC information/signature below:

  I hereby authorize any remaining balance on my account after my insurance pays on my family's claim(s) to be charged to my credit card below. I can revoke this authorization in writing at any time.

  _____ _____ _____ _____ Exp: _____ / _____ SID: _____

  Signature: _____ Date: _____

- ❑ Email my statement for any balance remaining after insurance pays – I will mail payment or call with CC# within 15 days
- ❑ Mail my statement w/Return Envelope for any balance remaining after insurance pays – I will mail payment or call with CC# within 15 days

David M. Hinton DDS, PA
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

'You May Refuse to Sign This Acknowledgement'

I have received a copy of this office's Notice of Privacy Practices.

I hereby give permission to discuss my medical/dental information with the following person/people, which will be in effect until revoked in writing: _____
_____
_____

_____
{please print name}

_____
{signature}

_____
{date}

========== FOR OFFICE USE ONLY ==========

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

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other {Please Specify}