HAWTHORNE DENTAL ASSOCIATES, PC

Patient Information

Patient Name: _____ Date:_____
Last First M I Preferred name

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Birth Date:_____ Social Security #:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext:_____ Cell Phone:_____
Email Address:_____

Health Information

Date of Last Dental Visit: _____ *Reason for this visit*:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ Mitral Valve Prolapse

Please list any medications you are currently taking

_____
_____ PHARMACY_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

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

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

If you are a student, name of school/college: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Assignment of Insurance Benefits and Release of Information

I, the undersigned, certify that I (or my dependants) have dental insurance coverage with_____
Name of Insurance Company

and assign directly to Hawthorne Dental Associates, PC all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

Responsible Party Signature _____ *Date* _____

Dental Health Information

1. Are you having any discomfort at this time? Explain: _____
2. Have you ever had any serious complications associated with previous dental procedures? Explain: _____
   _____
3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
   If so, when? _____
5. How often do you brush? _____
   Brush is: Soft _____ Medium _____ Hard
6. Do you have, or have you ever had any of the following? Please check those that apply:

MOUTH

- ❑ Bleeding, sore gums
- ❑ Unpleasant taste/bad breath
- ❑ Burning tongue/lips
- ❑ Frequent blisters, lips or mouth
- ❑ Swelling/lumps in mouth
- ❑ Braces
- ❑ Biting of cheeks/lips
- ❑ Clicking/popping jaw
- ❑ Difficulty opening or closing jaw

TEETH

- ❑ Loose teeth
- ❑ Sensitivity to heat
- ❑ Sensitivity to cold
- ❑ Sensitivity to sweets
- ❑ Sensitivity to biting
- ❑ Food impaction
- ❑ Clenching/grinding …
  If so, when? _____
- ❑ Shifting in bite
- ❑ Change in bite

7. Are you happy with your smile and the appearance of your teeth in general (Color, Shape, Spaces)? _____
   If "no", why not? _____
   _____
8. Do you smoke? Yes No Do you use any other tobacco product? _____
   Frequency of use: _____

Our Office and Financial Policies

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

APPOINTMENTS
Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care, and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a ***24-hour notice*** is expected. A fee of $50 will be charged for appointments missed without notice. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

INSURANCE
As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, ***we do require you to pay your deductible and/or "estimated patient portion" at the time of service***. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card and a claim form if needed. We must be able to verify coverage before we can accept assignment of benefits. Please note that dental insurance plans are different from your medical insurance. Each plan has different yearly deductibles and benefits. Most insurance plans will pay, at most, 80% of Basic procedures and 50% of Major procedures. When possible, we will submit a dental pre-estimate to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I am responsible for reading and understanding my dental insurance benefits._____
initial

PAYMENT OPTIONS AND ACCOUNT INFORMATION
We do not send monthly statements. If a balance is over 30 days, a billing fee will be charged at the rate of 1.5% per month of the total balance. In the event we receive a returned check for insufficient funds or a closed account, there will be a $35.00 fee charged to your account.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA and MASTERCARD, AMEX, DISCOVER, CARE CREDIT

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

I have read, understand, and agree to the above office and financial policies.

X _____ _____
Signature of patient or responsible party Date