

Hunt Family Dental Care

Adam C. Hunt, DMD

Welcome to the Practice

Please let us know whom we can thank for referring you to our office: _____

At this office, every patient is special. It is our goal to help you experience the wonderful benefits of good dental health. Strong, good looking teeth enable you to eat better, look better and feel confident about your smile and yourself. A beautiful smile is a precious gift that you can give every person you meet everyday of your life. We can help you have that beautiful smile.

Our mission is to create a warm friendly professional environment that provides the highest level of dental care available. We pride ourselves on the service we provide to our patients. If you ever have any questions about your treatment or any other concerns, please ask myself or any member of my staff. We will be pleased to assist you. All the members of our staff welcome you and look forward to working with you to create beautiful healthy teeth for you for a lifetime.

It is important for you to know what will happen at your new patient visit. **Children** (under 18) will receive a comprehensive examination, x-rays, cleaning and fluoride treatment. **Adults** will receive a comprehensive examination, a full mouth series of x-rays, periodontal assessment and routine cleaning if oral health permits. If oral health does not permit a routine cleaning another appointment will be scheduled accordingly.

Below is a list of office policies all patients need to be familiar with.

1. Our office is completely paperless and digital. If you have digital quality x-rays from another office you may have them e-mailed to the office at huntfamilydental@gmail.com. All x-rays must be received prior to your first appointment.
2. All orthodontic patients need to have their wires removed prior to all cleaning appointments.
3. Appointment reminders are sent as a courtesy via our automated system. Please be sure to provide and e-mail address and phone number for text messages.
4. As a courtesy to all our patients, those who arrive more than 10 minutes past their scheduled appointment time will be required to reschedule. We respect your reserved time and will do our best to see you promptly. However, we occasionally experience delays and ask that you please be patient.
5. A 24 hour cancellation policy is effective for all appointments. Failure to give a 24 hour notice may result in a fee being charged to you. Fees are based on the length of the appointment.
6. **DO NOT** bring children with you to your appointment that are not able to sit unattended in the reception room. Only the patient receiving treatment is allowed in the operatory.

Patient Name

Date

Signature
(Patient or Responsible Party)

Relationship to Patient

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No	

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: Policy Holder

Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec.: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Emergency Contact: _____

Student Status: Full Time Part Time

Emergency #: _____

Medicaid ID: _____ Pref. Dentist: _____

Physician's Name: _____

Employer ID: _____ Pref. Pharmacy: _____

Physician's #: _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Hunt Family Dental Care

Adam C. Hunt, DMD

Treatment Consent Form

What you are being asked to sign is a confirmation that we have discussed the nature and the purpose of dental treatment, the known risks associated with dental treatment, and the feasible treatment alternatives, and that you have been given an opportunity to ask questions and all your questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand. My signature on the bottom of this form certifies that:

1. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.
2. I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.
3. I understand that the estimate given to me is for normal and usual treatment. I understand that if my treatment requires extra time, additional procedures or additional laboratory work, there will be additional fees related to the additional time and treatment.
4. I understand that Dr. Hunt has carefully examined my mouth. Alternatives to the chosen treatment have been explained. I have been informed and I understand the purpose and the nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of the prostheses.
5. I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.
6. I have been informed of the possible risks and complications involved with dental treatment that include but are not limited to: root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.
7. I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth and/or roots, difficulties in chewing and/or speech. Also, possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
8. Dr. Hunt has explained that there is no method to accurately predict the outcome of dental treatment due to large variations in teeth, gums, bone, chewing forces, and oral hygiene. It has been explained to me that in some instances dental treatment may not be successful.
9. I agree to follow the home care instructions provided to me. I agree to report to Dr. Hunt for regular examinations as indicated and I understand that this office will monitor my oral health.

10. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, any blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

11. I consent to photography, study models and X rays of the procedure to be performed for use in teaching dentistry and other graphic purposes.

12. I understand that with any dental treatment, my teeth, gums or bone can be damaged by bacteria and I must do my utmost to remove the bacterial plaque off all the surfaces of all my teeth and/or implants every day. If I do not clean my teeth and/or implants properly, I may get decay and/or gum disease and my treatment may fail. I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment.

Patient Name

Date

Signature
(Patient/Responsible Party)

Relationship to Patient

Hunt Family Dental Care
Adam C. Hunt, DMD

Authorization of Use and Disclosure of Protected Health Information

1. The information covered by this authorization includes:
 - Appointments, Account and Treatment Information
2. Authorization is given to Hunt Family Dental Care to disclose information as indicated above.
3. My personal information may be discussed with and disclosed to the following individuals:
 - Please list any individual that may contact our office on your behalf such as a spouse, child, sibling, ect.

Name of Person - Relationship

Name of Person – Relationship

Name of Person - Relationship

This authorization is effective one year from today unless revoked or terminated by the patient or patient’s personal representative.

You may revoke or terminate this authorization by submitting written revocation to Hunt Family Dental Care.

Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The Privacy of this information may not be protected under the federal privacy regulations.

Patient Name (Print)

Date

Signature (Patient/Responsible Party)

Relationship to Patient

Hunt Family Dental Care Financial Policy

Dr. Adam Hunt welcomes you to our facility. We strive to provide you with exceptional care and our goal is to make your visit as convenient as possible.

By Signing below you confirm that you have read this policy and understand the following:

- It is your responsibility to inform our office of any contact information change including: address, email or phone number changes.
- We request your account be kept current. All self-pay or insurance co-payments, co-insurance and deductibles will be collected at the time of service. Payable by cash, check, credit card and care credit.
- If you do not have payment at the time of service your appointment will be rescheduled.
- A return check will result in a \$35 service charge and all future payments will be requested in the form of cash or a credit card at the time of service.
- If your account is turned over to a collection agency, you will be responsible for any additional costs incurred in collection of said balance, which may include collection agency fees, court costs and attorney fees.
- Senior Citizens (age \geq 65), who do not have dental insurance, will receive a courtesy discount of 10%

Dental Insurance Coverage

We are glad to submit your claims, however we emphasize that as dental providers, our relationship is with you, not your insurance company. Although we attempt to verify your insurance benefits, please be advised this is only an estimate of your coverage based on information provided to us at the time of inquiry.

By signing below you confirm that you have read this policy and understand the following:

- It is your responsibility to inform us of any insurance policy changes prior to your appointment.
- Authorizations are not a guarantee of payment.
- All service may not be covered under your insurance plan.
- It is your responsibility to be aware of what service or services are being provided to you and if it is covered under your insurance plan.
- You are responsible for all and any covered and non-covered charges payable by your insurance company.
- Filing your insurance claim is a courtesy extended to you; all charges are always your responsibility from the date services are rendered.
- You may be billed directly if your insurance plan does not provide payment in an appropriate time frame.

We realize that temporary financial problems arise and may affect timely payment. We urge you to contact our office immediately for assistance in the management of your account. We are here to assist you, please do not hesitate to ask for assistance.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient Name (Print)

Date

Signature
(Patient/Responsible Party)

Relationship to Patient