New Patient Form

HINER FAMILY DENTISTRY

PATIENT INFORMATION

*Required Fields

Patient First Name:*

Middle Name:

Last Name:*

DOB:*

How do you wish to be addressed?

Address:*

City:*

State:*

Zip:*

Home Phone#:*

Cell Phone#:

Work Phone#:

Email:

How did you hear about our practice?:

INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber Name:

Subscriber ID:

DOB:

Relationship to Subscriber:

Employer Name:

Employer Phone:

Insurance Company: | Insurance Group: | Insurance Phone#:

RESPONSIBLE PARTY (MINOR UNDER 18 ONLY)

First Name: | Middle Name: | Last Name:

DOB: | Email:

Address (If different):

City: | State: | Zip Code:

Home Phone#: | Cell Phone#: | Work Phone#:

EMERGENCY CONTACT

First Name: | Middle Name: | Last Name:

Home Phone#: | Cell Phone#: | Work Phone#:

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) healthcare, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS:

I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and healthcare operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by contacting Hiner Family Dentistry at (713)667-6478.

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DENTAL HISTORY

*Required Fields

Reason for today's visit:

Former Dentist:

Date of last dental visit:

Date of last dental x-rays:

Please check if you have/had any of the following:

	Yes	No
Bad breath	○	○
Blisters on lips or mouth	○	○
Burning sensation on tongue	○	○
Chew on one side of mouth	○	○
Cigarette, pipe, or cigar smoking	○	○
Smokeless tobacco	○	○
Dry mouth	○	○
Food collection between teeth	○	○
Clench or grind teeth	○	○
Growths or sore spots in your mouth	○	○
Gums swollen, tender or bleeding	○	○
Head, neck, jaw pain, or aches	○	○
Lip or cheek biting	○	○
Loose teeth or broken fillings	○	○

Mouth breathing	○	○
Orthodontic treatment	○	○
Periodontal treatment	○	○
Sensitivity to pressure or irritants (cold, heat, sweets)	○	○

How often do you floss?

How often do you brush?

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics?

○ Yes
○ No

If Yes, please explain:

Have you ever had trouble from previous dental care?

○ Yes
○ No

If Yes, please explain:

MEDICAL HISTORY

Physician's name:

Date of last visit:

Physician's address:

Have you had any serious illnesses or operations?

○ Yes
○ No

If yes, please describe:

Have you ever had a blood transfusion?

○ Yes
○ No

If yes, give approximate dates:

FOR WOMEN:

Yes No

If Pregnant, Due date:

Are you pregnant?	○	○
Nursing?	○	○
Taking birth control pills?	○	○

Please check if you have/had any of the following:

	Yes	No		Yes	No		Yes	No
Anemia	○	○	Hay Fever	○	○	Rheumatic Fever	○	○
Arthritis, Rheumatism	○	○	Headaches	○	○	Scarlet Fever	○	○
Artificial Heart Valves	○	○	Heart Murmur	○	○	Shortness of Breath	○	○
Artificial Joints	○	○	Hepatitis A	○	○	Sinus Trouble	○	○
Bleeding abnormally with operations or surgery	○	○	Hepatitis B or C	○	○	Sickle cell anemia	○	○
Blood disease, clotting disorders	○	○	Herpes	○	○	Skin rash	○	○
Cancer	○	○	High Blood Pressure	○	○	Slow healing wounds	○	○
Chemical Dependency	○	○	High Cholesterol	○	○	Stroke	○	○
Chemotherapy	○	○	Any immune deficiency	○	○	Swelling of feet or ankles	○	○
Circulatory problems	○	○	Jaundice	○	○	Thyroid Problems	○	○
Cortisone Medicine	○	○	Kidney Disease	○	○	Tonsilitis	○	○
Cough, persistent or Bloody	○	○	Low Blood Pressure	○	○	Tuberculosis	○	○
Diabetes	○	○	Mitral Valve Prolapse	○	○	Tumor or growth on head/neck	○	○
Emphysema	○	○	Osteoporosis	○	○	Ulcer	○	○
Epilepsy	○	○	Pacemaker	○	○	Venereal disease	○	○
Fainting	○	○	Radiation Treatments	○	○	Weight loss, unexplained	○	○
Glaucoma	○	○	Respiratory disease	○	○			

Asthma:

○ Yes
○ No

If Yes, Required Hospitalization

○ Yes
○ No

Have you used steroids:

○ Yes
○ No

Date of last episode:

_____

Do you wear contact lenses?

- ○ Yes
- ○ No

Do you consume alcoholic beverages?

- ○ Yes
- ○ No

Are you currently under the care of a Physician?

- ○ Yes
- ○ No

Are you allergic/sensitive to Latex?

- ○ Yes
- ○ No

Allergic to Penicillin, Aspirin, or other drugs?

- ○ Yes
- ○ No

If Yes, please specify:

List any medications that you are taking:

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: *

Date:*

MEDICAL HEALTH HISTORY – UPDATE AND EXCEPTIONS

☐ I have read my medical history and confirm that it adequately states past and present conditions

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HINER FAMILY DENTISTRY

PRIVACY PRACTICES RECEIPT / CONSENT FORM

*Required Fields

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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

Notice of Privacy Practices:
You have the right to read the 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 disclosures 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: Kristina Brady
Telephone: (941)274-0820

Right to Revoke:
You will have the right to revoke this Consent at any time by giving us written notice of your 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 your revocation.

- ☐ I have had full opportunity to read and consider the contents of this Consent form and the 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 heath care operations.
- ☐ I understand that by signing this Consent form, I am giving my consent to to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)
I request the office to restrict the disclosure of my PHI to those specified below:

Patient Signature or Personal Representative *

_____

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HINER
FAMILY DENTISTRY

FINANCIAL POLICY

*Required Fields

• ALL PATIENTS MUST COMPLETE OUR “PATIENT INFORMATION FORM” BEFORE SEEING THE DENTAL PROFESSIONAL.

• FULL PAYMENT IS DUE AT TIME OF SERVICE.

• WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.

• WE PROVIDE INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE

• WE WILL INFORM YOU IF THERE IS A BALANCE OR CREDIT AFTER THE INSURANCE COMPANY PAYS THEIR PORTION. A CREDIT CAN BE SENT TO YOU IN THE FORM OF A CHECK OR KEPT ON YOUR ACCOUNT FOR FUTURE DENTAL WORK. ANY BALANCE NOT PAID BY THE INSURANCE WILL BE THE PATIENT'S RESPONSIBILITY.

• INVOICES WILL BE SENT AT 0, 30, 60, AND 90 DAYS. A BALANCE NOT PAID OR SET UP FOR RECURRING PAYMENTS DURING THIS TIME WILL BE SENT TO A COLLECTIONS AGENCY.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre authorized to an approved credit plan, or to Visa, Master Card or Discover.

INSURANCE

We provide insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan’s limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by our team regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Drs. Hiner. However, if you are paid by the insurance company instead of Drs. Hiner you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: *

Date:*