New Hope Family Dentistry P.C.

nhfamilydentistry@gmail.com

www.newhopefamilydentistry.com

[redacted] Main Drive · New Hope, AL 35760 [redacted]

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: ___-__-____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Occupation: _____

Spouse, Parent, or Guardian name and phone numbers:

_____

_____

Emergency Contact and phone numbers:

_____

_____

How did you hear about us? Whom may we thank for referring you to our practice?

_____

_____

Dental History

When was your last dental visit?

_____

_____

Who was the providing dentist?

_____

_____

When was your last dental cleaning?

Your Mouth

Reason for today's visit:

☐ Exam/Cleaning ☐ Consult ☐ Pain ☐ Cosmetic ☐ Missing Teeth ☐ Infection ☐ Broken Teeth
☐ Dentures/Partials ☐ Tooth Whitening ☐ TMJ/TMD Pain ☐ Implants

Would you like to improve your smile?

☐ No ☐ Yes

How are your gums?

☐ Seem healthy ☐ Bleed occasionally ☐ Bleed often ☐ Swollen

How are your teeth?

☐ No problems ☐ Sensitivity to hot/cold ☐ Sensitivity to sweets ☐ Sensitivity to chewing

How is your ability to chew?

☐ Fine ☐ Limited ☐ Needs help

How often do you brush?

How often do you floss?

If you could wave a magic wand - what would you fix about your teeth or smile?

Medical History

Please list your physician and phone number:

Date of last physical examination:

Have you had any recent hospitalizations or surgeries? If so, please list:

Please list any drugs or medications that you are allergic to:

Do you or have you ever taken any medications for osteoporosis such as: Zometa, Aredia, Boniva, Reclast, or Fosamax? ◯ Yes ◯ No

Are you currently taking a blood thinner medication? ◯ Yes ◯ No

Please list any medications you are taking:

Are you required by your physician to take antibiotic pre-medication before dental appointments? ◯ Yes ◯ No

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

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Codeine
- ☐ Demoral
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Do you have or have you ever had any other illnesses not listed above?

Do you smoke, use tobacco or vape? If so how much?

Ladies: Are you pregnant, or do you think you may be pregnant? If yes, when is your due date?

☐ By checking this box, I acknowledge that I have read this statement and agree to the contents: I understand that payment is my obligation regardless of insurance or any third party involvement. I certify that I have read and understand the information in this questionnaire. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I give consent to Drs. Brittany and Kyle Parks and her/his staff for treatment of my dental needs.

Signature:

_____

_____

Relationship to Patient - state "self" if you are the patient: _____

_____

Response Date: _____

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| 5487 Main Drive • New Hope, AL 35760 (256)723-8833

Office Policies

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Relationship to Patient - state "self" if you are the patient: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
* Obtaining payment from third party payers (e.g. my insurance company)
* The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, then you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occured prior to the date I revoke this consent is not affected.

Please flip page for Patient Consent Form

Patient Consent Form

Finances:

Financial arrangements must be made prior to treatment. We accept cash, check, VISA, and Discover cards. Third party financing options are also available. All co-pays and deductibles are due at the time services are rendered unless arranged prior to the appointment.

. A service charge of $30 will be applied to all returned checks.
. In the event of non-payment or default, the responsible party is responsible for all costs of collection, including but not limited to: collection agency fees, attorney fees, and court costs.
. I understand that for any treatment requiring services of a dental laboratory (crowns, bridges, partial, dentures, etc.) that my portion must be paid prior to the case being forwarded to the dental laboratory.

Insurance:

Insurance is a contract between you and your insurance company. Though we will do our best to help verify, each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by your insurance.

. As a courtesy to our patients, we will file your insurance claim for you. If your insurance company does not pay the claim within 60 days, you will be billed for the balance and it will be payable upon receipt.
. I understand that my insurance may pay only a portion of the claim(s) submitted and that I am ultimately financially responsible and agree to pay for all expenses incurred for services rendered by this office.
. I request that all insurance benefits be paid directly to New Hope Family Dentistry. If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the check or make payment immediately to New Hope Family Dentistry. I further authorize the release of information to my insurance company necessary to determine liability for payment and to obtain reimbursement of any claim.
. We will file most dental insurance and will always do our best to estimate the amount of your insurance benefit and subsequently the amount for which you will be responsible. We cannot, however, guarantee any insurance benefits. It is your responsibility to keep our office informed of any changes pertaining to your employment or insurance coverage.

Appointment Policy:

Appointments in our office are scheduled exclusively for you. Providing our staff with proper notification if a schedule change is required allows our staff the opportunity to schedule another patient that may wish to come in sooner to complete treatment. We require that you provide our office with at least 48 hours notice if an appointment change is necessary. Any missed, canceled, or changed appointments without providing our office the proper notice will be subject to a $25 fee.

Signature _____ **Date** _____

Response Date: _____

Non Covered Services

I, the undersigned patient, herby authorize Dr. Brittany and/or Dr. Kyle Parks to perform the procedures or courses of treatment. I understand and have discussed treatment options with the doctor and have been given a printed copy of the procedure treatment details.

I understand the risks inherent in the treatment. I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedures or courses of treatment.

I authorize Dr. Parks and any other qualified assistants or medical professionals to perform the procedures or treatments that were recommended. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures should they become necessary.

I have discussed payment options and agreed upon a form of payment. If my insurance is involved, I am aware that the insurance quotes are an estimate only and do not guarantee payment from my carrier. I understand the office will file my insurance for up to 60 days. If the insurance has not paid at the end of the 60 days I understand the total is my responsibility.

We want to provide you, the patient, with a choice of dental services. There may be certain services that you need that are not covered by your insurance policy. There may be services your insurance company claims to cover that are not reimbursed by your insurance to a financially competent level to cover expenses. For those services, you will be expected to pay the fee schedule difference for those items or pay for the service in full. For example, your insurance company will only pay for an amalgam (silver) fillings for posterior teeth when a composite (tooth colored) filling is sometimes recommended. You will be expected to pay the difference up to your insurance's fee schedule for that procedure. In addition, procedures that are considered cosmetic are not covered by your contract. Your insurance contract only pays for basic crowns, bridges, partials, and dentures. Your insurance does not cover the costs of crowns with custom shades, custom denture design, and or the luxury of local labs with quality control for the materials and faster case delivery. In addition, dental implants require multiple parts for construction of the implant crown, this is a separate non covered fee and will be reviewed with you prior to the ordering of specialized parts.

Here at New Hope Family Dentistry, we attempt to utilize your insurance for the maximum financial benefit. While we would hope our insurance PPO reimbursement fees would reflect the standard of care we strive to provider here for our patients, oftentimes they do not. If you have questions about any of this please let us know.

Signature: _____

Date: _____