Hamilton Town Dentistry
Patient Registration

1

Personal Information

Name:
Parent's Name (if child):
Address:
City: State: Zip:
Home Phone: Cell Phone:
Birthdate:
Social Security Number:
Email address:
Place of Employment
Work Phone:

2

Dental Insurance

Insurance Company:
Group #
Insured's information (if different than at left)
Name:
SSN:
Birthdate:
Employer:

3

Important Contacts

In Case of Emergency contact:
Relation:
Home Phone:
Work Phone:
Address:
City: State: Zip:
Who Referred You to Our Office?

4

Dental History

Do you have a specific dental problem? Yes No
If so, what?

Do you feel nervous about having dental treatment? Yes No

Are your teeth sensitive to hot, cold, sweets, pressure? Yes No
If yes, please circle all that apply.

Is there anything you would like to change about your smile?

Please rank the following in the order in which they would keep you from receiving dental care:

Fear of pain _____ Lack of concern _____

Cost of treatment _____ Missing work time _____

Consent for Treatment

The undersigned hereby authorizes the doctors and/or staff at Hamilton Town Dentistry to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors to perform any and all forms of treatment, medication and therapy, which may be indicated and further authorize and consent that the doctors choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I also assign all insurance benefits to the practice. Any payments received by the practice from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. We understand things come up, but kindly ask for a 48 hour notice of cancellation. I understand that if I cancel within 24 hours of my scheduled appointment, a cancellation fee of $40 will be assessed.

Patient Signature (Parent of Child): _____ Date_____ Witness: _____

Hamilton Town Dentistry

Dental History Form

Patient Name:_____ Date:_____

What is the main reason for your visit today?		
Date of Last Dental Visit:	Date of Last Dental Cleaning:	Date of Last Dental X-rays:

1. Do you have any dental concerns at this time? Yes No

   If so, please explain:_____

2. How often you do you have dental examinations? _____

   _____

3. Have you ever had:

   a. Orthodontic treatment Yes No

   b. Oral surgery Yes No

   c. Periodontal treatment Yes No

   d. Your bite adjusted Yes No

   e. A bite plate or mouth guard Yes No

   f. A serious injury to the mouth or head? Yes No

   If yes, please describe _____

   _____

4. TMJ.

   Have you ever experienced:

   a. *Clicking* of the jaw? Yes No

   b. Difficulty in *opening or closing*? Yes No

   c. Difficulty in *chewing*? Yes No

5. Habits.

   Do you:

   a. Clench or grind your teeth? Yes No

   b. Bite your lips or cheeks regularly? Yes No

   c. Hold foreign objects with your teeth?

   (pencils, pipes, pins, nails, fingernails) Yes No

   d. Have tired jaws, especially in the morning? Yes No

   c. How often do you:

   brush _____ floss _____

   d. What other dental aids do you use? _____

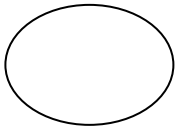
6. Does food ever get caught between any of your teeth? Yes No

7. Do you suffer from bleeding or swelling in your gums? Yes No

8. Are you dissatisfied with the appearance of your teeth? Yes No

9. On a scale of 1-10, how would you rate your teeth?

   (1 being the worst, 10 being the best)



10. Do you feel nervous about dental treatment? Yes No

    If so, what is your biggest concern _____

    _____

11. Have you ever had an upsetting dental experience? Yes No

    If so, please describe _____

    _____

Is there anything else about having dental treatment that you would like us to know? _____

_____

Time 10:46 AM | Hamilton Town Dentistry | Date 8/15/2017

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

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, c

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X Date:_____

HAMILTON TOWN DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT:

Name: _____
Address: _____ City: _____ State: ____ Zip: _____
Telephone: _____ Social Security #: _____

SECTION B: 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 our 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. 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 our office at (317) 773-9992 or by mailing us at 14139 Town Center Boulevard, Suite 200, Noblesville, IN 46060.

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 address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your 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 health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following.

Personal Representative's Name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

HAMILTON TOWN DENTISTRY

Hamilton Town Dentistry
14139 Town Center Blvd Suite #200
Noblesville, IN 46060
317-773-9992
main@HamiltonTownDentistry.com

Office Financial Policy

At Hamilton Town Dentistry, our team strives to provide quality, personalized care to each of our patients. The office financial policy is in place to make sure we are on the same page with our patients in regards to financial and insurance policies.

Payment is expected at time of service. We will accept cash or credit card. We accept all private insurance plans and are contracted in-network providers for many of the major insurance companies We will file your claims as a courtesy to you at no charge. It is the patient's responsibility to provide us with current insurance information a minimum of 24 hours prior to appointment time to ensure we have adequate time to research your insurance on your behalf. You will be responsible for full payment at the time of service if we are not given adequate time to verify your insurance benefits.

If any payment from an insurance company becomes 90 days past due, you will immediately be billed for the entire balance. It is important to recognize that your insurance contract is between you and your insurance company. We will do our very best to help you obtain your dental benefits from your insurance company but it is ultimately your responsibility to follow-up with your insurance company if needed to attempt to obtain benefits. We will file pre-treatment estimates, AT YOUR REQUEST ONLY. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases it may delay important dental care.

Not all services are covered by insurance. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Our staff can never guarantee your eligibility and coverage as often times insurance companies give us incorrect information when we call to do a benefits analysis. Insurance limitations and regulations vary with all insurance plans. Therefore, if your insurance plan denies a service, you will be responsible for the complete charge. We do not base your treatment plan on what your insurance plan covers or doesn't cover. **We are working for YOU, not the insurance company.**

Please keep in mind that a specific amount of time is reserved especially for you when an appointment is scheduled. We encourage all patients to keep their scheduled appointments, but do recognize that something may come up that requires you to reschedule your appointment. **We kindly ask for a 24 hour notice for any cancellations or appointment changes. Failure to give a minimum of a 24 hour notice will result in a $40 fee being applied to your account. For longer procedures, a non-refundable deposit will be required to reserve your spot on the schedule.**

Past due accounts may be turned over to a collection agency. Any fees incurred due to this, will be added to the outstanding balance. This may include late fees, collection agency fees, court fees, etc.

Notice to Insurance Patients

I am responsible for my balance if any of the following occurs:

- The treatment goes over my yearly maximum.
- Any treatment is denied by my insurance company.
- I am not eligible for insurances.
- I prevent or delay payment by not complying with requests for insurances forms or signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab costs are incurred due to missing appointments.
- **I received my insurance check and do not send it to your office.**

I hereby authorized payments directly to the above-named dentist **(Assignment of Benefits)** of the group insurance benefits otherwise payable to me but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the foregoing treatment plan and authorized release of any information relating to this claim. I have read and understand my obligation of my dental insurances as payment.

_____ _____

Patient/Guardian Signature **Date**