

First Name: _____		Middle Initial _____	Last Name: _____	
Preferred Name: _____		Date of Birth: _____	Patient SSN: _____	
Address: _____		Apt _____	City: _____	State: _____ Zip Code: _____
Cell Phone: _____		Home Phone: _____		Sex: Male Female
Marital Status: Married Single Divorced Separated		Email: _____		
<b>Primary Insurance:</b> Company: _____		Group no. _____	ID no. _____	
Subscriber Name: _____		SSN: _____	Phone: _____	
Date of Birth: _____		Employer: _____		
<b>Secondary Insurance:</b> Company: _____		Group no. _____	ID no. _____	
Subscriber Name: _____		SSN: _____	Phone: _____	
Date of Birth: _____		Employer: _____	How you heard about us: _____	

**Payment for service:** Payment is due at the time of service. Partial payment will not be accepted unless otherwise arranged in advance. **Please be aware that if a balance remains unpaid, we will refer you to an external collections agency, and your account will be charged a \$250.00 collection fee.** At that point you will be discharged from the practice.

**Insurance:** As a courtesy, we will bill your primary and secondary insurance companies. Estimates will be given to the best of our ability based on your individual policy for any service rendered. Estimated patient portions must be paid at the time of service. Please be aware that some or all of the services you receive may not be covered by your insurance. **It is your responsibility to know which services your insurance will cover and how much they will pay for them.** We are happy to assist you in finding out what your coverage includes. **Any insurance payment quotes are an estimate and are NOT a guarantee of payment. You will be responsible for any balance not covered by your insurance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.** Any questions regarding details of your coverage should be directed to your insurance carrier. We allow 90 days for your insurance company to pay your claim. After this time, you will be responsible for payment of any outstanding balances, and for further efforts to receive insurance payment.

To confirm your insurance eligibility and to submit insurance claims, we must have a copy of your current insurance card. We will also require the policy holder's information, including name, date of birth, social security number, and employer who is providing the insurance. If we do not receive this information in its entirety, your insurance carrier will not be billed and you will be responsible for the full cost of all services provided.

**Missed Appointments and Returned Checks:** Any appointment that is cancelled or rescheduled within 48 hours is subject to a \$50.00 missed appointment fee. Surgical appointments require 72 hours advanced cancellation notice, and are subject to a \$150.00 missed appointment fee. These charges are your responsibility and will be billed directly to you. **All returned checks will be subject to an external collection service, and a minimum fee of \$50.00 will be assessed for bank penalty charges incurred.** You will also be charged the cost of certified mailing in addition to the amount of your returned check.

**Credit Balance:** In the event that there is an overpayment that results in a credit balance on the account, all balances will remain on the account to be applied to future visits unless otherwise arranged for a refund. Refund requests must be made in writing and will be processed after a complete audit of the account. If the payment was made with a credit or debit card, the processing fee will be withheld from the refund.

**Authorization, Release, and Agreement to Pay:** ***I understand that before I receive any service at Hunsaker Dental, I must read and agree to this financial policy in its entirety.*** I authorize and hereby request my insurance company to pay directly to Hunsaker Dental any insurance benefits for services rendered at Hunsaker Dental. I understand that my dental insurance carrier may pay less than the actual fees for services. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan. **If I do not pay the entire new balance within 90 days of the date of service, a finance charge of 2.25% per month (27% annually) will be assessed to my account, in addition to monthly billing charges.** I realize that failure to pay my account will result in further action and that Hunsaker Dental will be unable to provide additional dental services on behalf of me and/or my dependents until such time as the account is paid in full. Any future services from that point on will be cash paid in full due at the time of service. In the event that I do not pay according to this agreement, I agree to pay collection costs and reasonable attorney fees associated with Hunsaker Dental's efforts to collect on this amount or any outstanding account balances. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

***I have read the above. I fully understand and accept the terms and conditions set forth.***

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient or responsible party: \_\_\_\_\_



## HIPAA Consent and Authorization

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

**You may communicate with the following individual(s) relating to my medical or payment information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Do not discuss my medical or payment information with anyone other than myself**

I authorize the professional office of Hunsaker Dental to release health information identifying me under the following terms and conditions:

1. At times it may be necessary to provide the patient's name and any applicable tooth number or numbers for needed treatment. No other identifying information is provided to outside providers
2. Information if released as stated above, to dental laboratories or other providers of dental care that may be involved in the continuing care of our patients
3. Information is released during the course of treatment for patients. Instances where this may be required is in the referral of patients to other providers, fabrication of permanent crown and bridge work, fabrication of dentures and partials, as well as the fabrication of other oral appliances.
4. There is no expiration date for this release and it is current through the course of treatment for the patient

**I acknowledge that I have read and been offered a copy of the Notice of Privacy Practices.**

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or legal Guardian Signature: \_\_\_\_\_

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because of the following:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Specify) \_\_\_\_\_



## Multimedia Consent and Release

I, (Patient Name) \_\_\_\_\_, do hereby give Hunsaker Dental, the right to photograph, film video, and/or record audio of me in connection with my patient care at any or all Hunsaker Dental locations. Photographs, video and audio recordings may be used to aid in the diagnosis and treatment of my conditions at Hunsaker Dental as well as training and quality assurance purposes for employees or persons acting on behalf of Hunsaker Dental.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Hunsaker Dental to take and use video, photographs and/or digital images, and or audio recordings of me to post in their office and/or on their media websites. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me.

I hereby release the Hunsaker Dental and all other persons/entities involved in acquiring the recordings from any and all claims and causes of action for any violation of any personal and proprietary right I may have related to these images / recordings, including without limitation, any claims or causes of action with respect to invasion of privacy, trespass, right to publicity, and defamation.

I acknowledge that I agree to the foregoing without receipt, demand, expectation or legal right to any compensation.

I have read this release and am fully familiar with and understand its contents.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### RELEASE FOR MINOR CHILDREN (Under 18)

I, (print name) \_\_\_\_\_, parent or official guardian of (child's name) \_\_\_\_\_ authorize Hunsaker Dental to take and use photographs and/or digital images of my child as noted above. I authorize the use of these images without compensation to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICAL HISTORY

**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: \_\_\_\_\_

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 If yes: \_\_\_\_\_

Do you use tobacco products?  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: \_\_\_\_\_

Do you use controlled substances?  Yes  No If yes: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed?  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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## DENTAL HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Please answer the following questions in order to help us better serve you.**

What is the reason for your visit today? \_\_\_\_\_

Are you experiencing any dental pain or discomfort?  Yes  No If yes: \_\_\_\_\_

Are any of your teeth sensitive to:  Hot  Cold  Sweets  Pressure

Have you noticed any mouth odors or bad tastes?  Yes  No

Does food get caught in your teeth?  Yes  No

Do you have a problem with dry mouth?  Yes  No

Do you clench or grind your teeth?  Yes  No

Do you have problems with your jaw joint?

Pain  Sounds  Locking  Popping  Limited Opening

Do you have any missing teeth?  Yes  No

If yes, which replacement options appeal most to you?

Dentures  Partial  Implants  Bridges  Other

Is there anything about the appearance of your teeth that you would like to change?

Spacing  Crowding  Rotated Teeth  Overbite  Shape of teeth  
 Color of teeth  Other  I'm happy with my teeth

Do you, or have you ever been told that you snore?  Yes  No

Have you ever been diagnosed with sleep apnea  Yes  No

Do you use, or have you ever used a CPAP Machine?  Yes  No

If yes, do you like your CPAP?  Yes  No

How often do you brush your teeth?

Twice per day or more  Once per day  Once every 2-3 days  Once per week  
 Once per month  Rarely  Never

How often do you floss?

Once or twice per day  A few times a week  Once per week  Once or twice per Month  
 Rarely  Never

Do you use any oral care item?  Yes  No If yes: \_\_\_\_\_

Do you have trouble cleaning or caring for your teeth?  Yes  No If Yes: \_\_\_\_\_

Have you ever had trouble getting numb or had any reactions to local anesthetic?  Yes  No If yes: \_\_\_\_\_

Do you feel nervous about dental treatment?  Yes  No If yes: \_\_\_\_\_

Do you have any other dental concerns or comments not listed? \_\_\_\_\_