Hardin
Cosmetic and Family Dentistry

Date:_____

Welcome

Name:_____ Date of Birth _____Sex _____

Address: _____City_____State ___Zip _____

Social Security_____ Home Phone_____ Cell Phone_____

Email_____ Driver's License _____

Check: Minor ___ Single ___ Married ___ Divorced ___ Widowed___

Patient (or Guardian) Employer_____ Phone_____ City_____

Spouse (or Guardian) Employer_____Phone_____City_____

How did you hear about us? _____

Emergency Contact_____ Phone_____

Responsible person for account _____

If you are filling this form out on behalf of another person, what is your relationship?

Name_____ Relationship_____

Primary Insurance

Insured's Name_____

Employer_____

Member ID/SS#_____

Insured's DOB_____

Insurance Co._____

Insurance Co. Address_____

Insurance Phone #_____

Group #_____

Secondary Insurance

Insured's Name_____

Employer_____

Member ID/SS#_____

Insured's DOB_____

Insurance Co._____

Insurance Co. Address_____

Insurance Phone #_____

Group # _____

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Financial Policy

All co-payments, deductibles and non-covered services are due when services are rendered. If you have dental insurance, we will estimate your benefits to the best of our ability. However, as the patient or the subscriber, you are responsible to know your insurance benefits, exclusions and policy details. If you are insured by two carriers, we will collect the portion estimated not to be covered by the primary plan. Once the secondary plan pays their portion, we will then send a refund or credit your account. Hardin Cosmetic and Family Dentistry will not take responsibility if an insurance company does not pay for treatment. **We can only provide an estimate of benefits, not a guarantee of payment.**

All co-payments, deductibles and non-covered services are due when services are rendered. Prior to your dental treatment, we do our best to provide you with an estimation of your total investment. All, if any, financial arrangements or options are to be done before the treatment is rendered. Insurance companies have 60 days to make payment on a claim. Inquiries after this time become the subscriber's responsibility. Cash, Check, Visa, MasterCard, American Express, Discover and financing are all available.

I understand that I am financially responsible for all services whether or not paid by my insurance carrier. In the event that my account is not paid, I agree to pay all cost of collection, including attorney fees, court cost, any billing charges and interest fees. A finance charge of 1.5% occurs on the account if the balance is not taken care of within 90 days and will continue until paid.

Patient Signature: _____ Date: _____
I have read and understand the policy written above.

Guarantor Signature: _____ Date: _____
(if different from patient)

If you are going to be unable to keep your scheduled appointment time, we ask that you please have the courtesy to call the office at least 48 hours prior to the appointment. **Hardin Cosmetic and Family Dentistry reserves the right to charge a fee for any appointment failed or cancelled without a 48 hour notice.** A patient or family may be dismissed from the practice due to failed appointments or failing to keep account balances paid.

Assignment of Benefit Form:

I do hereby give permission to Hardin Cosmetic and Family Dentistry, to complain on my behalf, to the insurance commissioner and to my insurance carrier for delaying of any payment on my claims. I understand that by law, my insurance company is required to pay promptly and can be held accountable for not doing so.

Patient Signature: _____ Date: _____

Are you currently under physicians' care? _____

If yes, please explain _____

Have you ever been hospitalized or had a major operation? _____

If yes, please explain _____

Have you had a serious illness in the last five years? _____

If yes, please explain _____

Have you ever had a serious head or neck injury? _____

Please list all Prescription/Non-Prescription medications and Dose Time of Day

_____

_____

Do you take, or have taken Phen-Fen or Redux? _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? _____

Do you smoke or use smokeless tobacco? _____

Are you a former tobacco user, if so, how many years? _____

Do you drink alcoholic beverages? _____

Do you use any illicit street drugs? _____

Do you wear contact lenses? _____

Do you have pain/sounds in your Temporomandibular joints? _____

Other Allergies _____

Women—Are you pregnant/trying to get pregnant? _____

Taking oral contraceptives? _____ Nursing? _____

Other Medical Comments

Have you had any serious illnesses not listed above? _____

Additional Comments or Concerns for Dr. Hardin? _____

MEDICAL ALERTS

ALLERGIC TO

Aspirin	Y/N	Penicillin	Y/N	Codeine	Y/N
Acrylic	Y/N	Metal	Y/N	Latex	Y/N
Sulfa Drugs	Y/N	Local Anesthetics	Y/N	Iodine	Y/N
Other Antibiotics	Y/N	Other Narcotics	Y/N	Sedatives	Y/N
other Allergies	Y/N				

DO YOU NEED TO PREMEDICATE? Y/N

CHECK ALL THAT APPLY

AIDS/HIV Infection	Y/N	Alzheimer's Disease	Y/N	Anaphylaxis	Y/N
Anemia	Y/N	Angina	Y/N	Anxiety Disorder/Panic Attacks	Y/N
Arthritis/Gout	Y/N	Artificial Heart Valve	Y/N	Artificial Joint	Y/N
Asthma	Y/N	BloodDisease/AbnormalBleeding	Y/N	Blood Transfusion	Y/N
Breathing Problems	Y/N	Bruise Easily	Y/N	Cancer/Radiation Treatment	Y/N
Cardiovascular Disease	Y/N	Chemotherapy	Y/N	Chest Pains	Y/N
Cold Sores/Fever Blisters	Y/N	Congenital/Inborn Heart Defect	Y/N	Convulsions	Y/N
Cortisone Medicine-last 2 years	Y/N	Chrohn's Disease or Colitis	Y/N	Depression	Y/N
Diabetes	Y/N	Diabetes-Insulin Treated	Y/N	Drug Addiction	Y/N
Emphysema/Bronchitis/COPD	Y/N	Epilepsy or Seizures	Y/N	Excessive Thirst	Y/N
Fainting Spells/Dizziness	Y/N	Frequent Cough	Y/N	Frequent Diarrhea	Y/N
Frequent Headaches/Migrains	Y/N	Glaucoma	Y/N	Heart Attack/Failure	Y/N
Heart Murmur	Y/N	Heart Pacemaker/Defibrullator	Y/N	Heart Trouble/Disease	Y/N
Hemophilia	Y/N	Hepatitis A or C	Y/N	Hepatitis B	Y/N
High Blood Pressure	Y/N	Hives or Rash	Y/N	Hypoglycemia	Y/N
Irregular Heartbeat	Y/N	Kidney Disease/Failure	Y/N	Liver Disease	Y/N
Low Blood Pressure	Y/N	Lung Disease	Y/N	Mitral Valve Prolapse	Y/N
Osteoporosis	Y/N	Pain in Jaw Joints	Y/N	Parathyroid Disease	Y/N
Psychiatric/Mental Health Issue	Y/N	Radiation Treatment	Y/N	Renal Dialysis	Y/N
Rheumatic Fever/Damaged Heart	Y/N	Rheumatism	Y/N	Scarlet Fever	Y/N
Shingles	Y/N	Shortness of Breath	Y/N	Sickle Cell Disease	Y/N
Sinus Trouble	Y/N	Sleep Apnea	Y/N	Stomach/Ulcers/Reflux/Acidity	Y/N
Stroke	Y/N	Swelling of Limbs	Y/N	Swollen Glands-Persistant	Y/N
Thyroid Disease	Y/N	Venerial Disease	Y/N	Yellow Jaundice	Y/N

See Scanned Documents or Patient Notes:

Blood Thinners Y/N

Additional Comments:

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HIPAA Acknowledgement and Confidential Communication Agreement

Patient Name:_____ DOB: _____

I, _____, hereby acknowledge that I received a copy of this dental practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature: _____ Relationship:_____

Release of Information

- □ I authorize the release of personal information, such as diagnosis, treatment, finances and other personal information, to the following individuals. (Leave blank if this does not apply)
  Name:_____ Relationship:_____
  Name:_____ Relationship:_____
  Name:_____ Relationship:_____
- □ I authorize Hardin Cosmetic and Family Dentistry to contact me at the following:
  Telephone:_____ May we send text? Yes _____No_____
  Email: _____
  If unable to reach me:
  - □ You may leave me a **detailed message**
  - □ You may leave a message asking me to return your call

I understand that this agreement remains in effect until revoked by me in writing. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name:_____ Relationship:_____

(For Office Use Only)

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment was not signed because:

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