New Patient Paperwork

DR.CHRIS HOUSER, D.M.D., P.C. – HERITAGE HUNT DENTAL

Full Name: _____ **Nickname:** _____

Dental History

When was your last cleaning and exam?	**X-rays?**	**Dental Visit?**
How often do you brush?	**Floss?**	**Other Hygiene Method(s)?**

Do you currently have problems with any of the following (please check yes or no):

Please Check:	Y	N
Bad Breath		
Loose Teeth		
Dry Mouth		
Difficulty Chewing		
Bleeding Gums		
Mouth Breathing		
Fingernail Biting Habit		

Please Check:	Y	N
Tooth, Mouth, Or Facial Pain		
Food Collecting Between Teeth		
Teeth Sensitive To Cold Or Hot		
Teeth Sensitive To Biting		
Teeth Sensitive To Sweets		
Snoring		
Sleep Apnea		

Please Check:	Y	N
Clicking Or Popping Jaw		
Grinding Or Clenching Teeth		
Burning Sensation On Tongue		
Sores- Mouth, Head, Neck		
Swelling- Mouth, Head, Neck		
Broken Teeth or Fillings		
Dental Treatment Anxiety		

Do you have any of the following cosmetic concerns?

Please Check:	Y	N
Discoloration Of Teeth(Yellow/Gray)		
Metallic Fillings Or Crowns		
Spacing, Crowding, Misalignment Of Teeth		
Chipped Or Misshapen Teeth		
Other(Please Specify):		

Any interest in the following cosmetic services?

Please Check:	Y	N
Whitening/Bleaching		
Replace Metallic Restorations with White		
Invisalign®- Invisible Alternative To Braces		
Porcelain Veneers, Bonding		
Other		

Please use the space below to elaborate on any of the above or to describe other dental concerns not listed above:

_____

How did you hear about our office?

☐ Referral (Please Specify): _____

☐ Insurance (Website): _____

☐ Google/Online (Please Specify): _____

☐ Other (Please Specify): _____

Where are you originally from?

Are you a Veteran?

Hobbies/Interests:

MEDICIAL HISTORY QUESTIONAIRE

HEIGHT:	**WEIGHT:**	**DOB:**	**GENDER:** ◯ **M** ◯ **F**
PHYSICIAN:	**NUMBER:**	**DATE OF LAST EXAMINATION:**	

Have you been under the care of a physician for any condition, had an operation, or been hospitalized in the past 5 years? ◯ **Y** ◯ **N**
If yes, please describe:

Medication: Please list below and reason for use (if known). Include over-the-counter drugs and supplements:

Do you take Blood Thinners? ◯ **Y** ◯ **N**

Prescription Pain Medicine? ◯ **Y** ◯ **N**

PHARMACY:	**LOCATION:**	**NUMBER:**

Tobacco Products? ◯ **Y** ◯ **N** **Alcoholic Beverages?** ◯ **Y** ◯ **N** **Recreational Drugs?** ◯ **Y** ◯ **N**

SPECIFY FREQUENCY OF USE:

ALLERGIES:
☐ **MEDICATION(Specify):**
☐ **LATEX** ☐ **LOCAL ANESTHETICS** ☐ **METALS** ☐ **SEASONAL**
☐ **OTHER(Specify):**

WOMEN ONLY: PREGNANT? ◯ **Y** ◯ **N**
DUE DATE:
NURSING? ◯ **Y** ◯ **N**

Please check yes or no whether you have had any of the following:

Please Check:	Y	N
Heart Murmur		
Rheumatic Fever		
Artificial/Damaged Heart Valves		
Angina		
Congestive Heart Failure		
Heart Attack		
High Blood Pressure		
Diabetes		
Mitral Valve Prolapse		
Subacute Bacterial Endocarditis		
Orthopedic Joint Replacement		
Arteriosclerosis		
Coronary Artery Disease		
Pacemaker		

	Y	N
Tuberculosis		
Mental Health Disorder		
Chemical Dependency		
Chronic Pain		
Osteoporosis		
Glaucoma		
Sleep Apnea		
AIDS/HIV		
Asthma		
Anemia		
Gastrointestinal Disease		
Autoimmune Disease		
Epilepsy or Seizure Disorder		
Stroke		

	Y	N
Blood Clotting Problems		
Hepatitis/Liver Disease		
Respiratory Problems		
Kidney Disease		
Thyroid Problems		
Immuno-Suppression Condition		
Cancer		
Sexually Transmitted Disease		
Eating Disorder		
Migraines		
Back Problems		
Arthritis		
Sinus Problems		
Other:		

Please use the space below to elaborate on any of the above or to explain any other condition not listed above.

_____

Patient/Guardian Signature: _____ **Date:** _____

NEW PATIENT REGISTRATION

Patient's Personal Information:

FULL NAME:		**NICKNAME:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
HOME:	**CELL:**	**EMAIL:**	
DOB:	**GENDER ◯ M ◯ F**	**SSN:**	
EMPLOYER:		**OCCUPATION:**	
STUDENT STATUS: ◯ N/A ◯ FULL-TIME ◯ PART-TIME			
MARTIAL STATUS: ◯ SINGLE ◯ MARRIED ◯ SEPARATED ◯ DIVORCED ◯ WIDOWED			

Person Responsible for Account (If different than patient):

FULL NAME:		**NICKNAME:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
HOME:	**CELL:**	**EMAIL:**	
DOB:	**GENDER ◯ M ◯ F**	**SSN:**	
EMPLOYER:		**OCCUPATION:**	

Primary Insurance Subscriber and Carrier Information (If different than above):

FULL NAME:	**DOB:**	**ID/SSN:**
PRIMARY INSURANCE COMPANY:		
GROUP NUMBER:	**EMPLOYER:**	

Secondary Insurance Subscriber and Carrier Information (If different than above):

FULL NAME:	**DOB:**	**ID/SSN:**
PRIMARY INSURANCE COMPANY:		
GROUP NUMBER:	**EMPLOYER:**	

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Financial Authorizations and Agreements

Appointments:

Every appointment you schedule is reserved exclusively for you. **There is a fee for failing to keep appointments**. We understand that occasionally due to circumstances beyond your control it may be necessary to reschedule an appointment. We ask that you kindly give at least **48 hours' notice** for any appointment changes.

Initial: _____

Patient Privacy:

I have received a copy of this office's "Notice of Privacy Practices" and consent to your use and disclosure of my protected health information to carry out treatment, payment activities (eg. in connection with insurance claims), healthcare operations, or when required by law. I understand my rights concerning my health information.

Initial: _____

Financial Matters:

Dr. Houser only places white/tooth-colored fillings (composite resin). Your insurance company may downgrade your benefit to the silver-mercury filling (amalgam) fee and you will be responsible for the difference in cost.

Initial: _____

All patients with an outstanding balance will receive a statement each month. We reserve the right to charge any outstanding balance over 30 days a finance charge of 1.5(18% APR). The returned check fee is $75. In the event that this account is turned over to an attorney for collection, you agree to pay all collection costs including interest charges, attorney's fees and court costs. We do realize that temporary financial problems may affect timely payment in some cases. We encourage open communication with our office in order to arrange mutually agreeable payment terms.

It is important for you to keep us informed of any changes in your employment and/or insurance. We will (in most cases) submit insurance claims for you. Any assistance in this matter does not imply any actual responsibility on our part. This is a courtesy we extend to you and, if necessary, will retract; thereby, making you responsible for all claims submissions. In this case, all fees (not just co-payments) would be due at the time services are rendered. We offer comfortable financing through **Care Credit** which offers up to 12 months no interest financing as long as you qualify as well as some in office financing. Please do not hesitate to ask us about these options.

I authorize direct payment of dental benefits to Heritage Hunt Dental. I acknowledge that my signature on this document authorizes my doctor to submit claims for benefits for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claims.

Payments for services rendered are due at time of service. I agree to make payment for all charges for dental services not paid for by my dental benefit plan (if applicable) at the time of service. If my insurance does not make payment to Heritage Hunt Dental within 60 days for the balance owed, I will take responsibility for payment.

Patient/Guardian Signature: _____ **Date:** _____

HERITAGE HUNT DENTAL
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MEDICAL RELEASE FORM

Patient name: _____

Date of Birth: _____

Phone Number: _____

Other Family Members to Transfer: _____

TRANSFER TO HERITAGE HUNT DENTAL:

Previous Dentist or Practice Name: _____

Practice Address: _____

Practice City/State/Zip: _____

Practice Phone Number: _____

Practice Email: _____

TRANSFER TO ANOTHER OFFICE:

Practice Name: _____

Practice Address: _____

Practice City/State/Zip: _____

Practice Phone Number/Fax Number: _____

Practice Email Address: _____

I hereby give you permission to release any and all of my records to or from Dr. Houser's office.

Patient/Guardian Signature: _____ **Date:** _____