HUNT Smile Design
excellence since 1924

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Today's Date ____ / ____ / ____ Would you like us to contact you via e-mail address? _____

Name - Last _____ First _____ MI ___ ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

I prefer to be called _____ ❑ Male ❑ Female Birthdate ____ / ____ / ____ Age _____

Social Security No. _____ - _____ - _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address - Street _____ Apt. _____ City _____ State ____ Zip _____

Phone - Home _____ - _____ - _____ Cell _____ - _____ - _____ Work _____ - _____ - _____ Ext. _____

Best time _____ and way to reach you ❑ Email ❑ Home phone ❑ Cell ❑ Work - okay to call work? ❑

Employer _____ How long there _____ Occupation _____

Employer Address - Street _____ City _____ State ____

Emergency Contact

Name _____ Relationship _____ Work phone _____ - _____ - _____

Address - Street _____ Apt. _____ City _____ State ____ Zip _____

Spouse or Person Responsible for Account

Name _____ Relationship _____ Social Security No. _____ - _____ - _____

Employer _____ Work phone _____ - _____ - _____ Ext. _____

Billing Address - Street _____ Apt. _____ City _____ State ____ Zip _____

How did you hear about us?

❑ Employee ❑ Radio ❑ TV ❑ Friend ❑ Family ❑ Yellow Pages ❑ Sign ❑ Website ❑ Doctor ❑ Other _____

Dental Insurance

Primary Insurance ❑ Dental Coverage ❑ Orthodontic Coverage Group No. (plan, local or policy no.) _____

Insurance Co. Name _____ Phone _____ - _____ - _____

Insurance Co. Address - Street _____ City _____ State ____ Zip _____

Policyholder's Name _____ Social Security No. _____ - _____ - _____ DOB ____ / ____ / ____

Employer _____ Employer Address _____ City _____ State ____ Zip _____

Secondary Insurance ❑ Dental Coverage ❑ Orthodontic Coverage Group No. (plan, local or policy no.) _____

Insurance Co. Name _____ Phone _____ - _____ - _____

Insurance Co. Address - Street _____ City _____ State ____ Zip _____

Policyholder's Name _____ Social Security No. _____ - _____ - _____ DOB ____ / ____ / ____

Employer _____ Employer Address _____ City _____ State ____ Zip _____

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Due to: ❑ Artificial Joints ❑ Artificial Valves ❑ Mitral Valve Prolapse
❑ Scarlet fever ❑ Rheumatic Fever ❑ Heart Surgery
❑ Immunodeficiency

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMO) ? ❑ Yes ❑ No

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No
If yes, what? _____

Do you still have wisdom teeth? ❑ Yes ❑ No

Do you have any of the following concerns? ❑ Hot / Cold Sensitivity
❑ Sensitivity to Sweets ❑ Bleeding Gums ❑ Painful Biting

Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change? _____

_____

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name _____

Address _____

Phone (_____) _____ Date of last visit ____/____/____

Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain _____

For Women: Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Unsure ❑ Yes ❑ No
Week # _____ Are you nursing? ❑ Yes ❑ No

Are you allergic to any of the following:

❑ Aspirin
❑ Barbiturates
❑ Codeine
❑ Dental Anesthesia
❑ Food Allergies
❑ Erythromycin
❑ Jewelry/Metals
❑ Latex
❑ Seasonal Allergies
❑ Other
❑ Sedatives
❑ Sulfa Drugs
❑ Tetracycline
❑ Penicillin

Please list additional drugs / materials that cause allergic reactions:

_____

_____

Are you taking any of the following?

❑ Acetaminophen
❑ Antibiotics
❑ Antihistamines
❑ Aspirin
❑ Blood Thinners
❑ Blood Pressure Medication
❑ Recreational Drugs
❑ Digitalis/Heart Medication
❑ Insulin/Diabetes Drugs
❑ Nitroglycerin
❑ Ibuprofen
❑ Steroids/Cortisone
❑ Thyroid Medicine
❑ Tranquilizers
❑ Naproxen
❑ Antidepressants

Please list any prescription and over-the-counter medications _____

_____

Do you now, or have you in the past, experienced the following?

❑ Abnormal Bleeding
❑ Alcohol Abuse
❑ Anemia
❑ Arthritis
❑ Artificial Bones/Joints
❑ Artificial Valves
❑ Asthma
❑ Blood Transfusion
❑ Cancer
❑ Chemotherapy
❑ Colitis
❑ Congenital Heart Defect
❑ Diabetes
❑ Difficulty Breathing
❑ Drug Abuse
❑ Emphysema
❑ Epilepsy
❑ Fainting Spells
❑ Fever Blisters
❑ Frequent Headaches
❑ Heart Attack
❑ Heart Murmur
❑ Heart Surgery
❑ Hemophilia
❑ Hepatitis
❑ High Blood Pressure
❑ HIV+/Aids
❑ Kidney Problems
❑ Liver Disease
❑ Low Blood Pressure
❑ Lupus
❑ Migraines
❑ Mitral Valve Prolapse
❑ Oral Herpes/Cold Sores
❑ Pacemaker
❑ Persistent Cough
❑ Psychiatric Problems
❑ Radiation Treatment
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ Sickle Cell Disease
❑ Sinus Problems
❑ Steroid Therapy
❑ Stroke
❑ Thyroid Problems
❑ Tonsillitis
❑ Tuberculosis (TB)
❑ Ulcers
❑ Venereal Disease

Please list any serious medical conditions that you have experienced _____

_____

Handicaps/Disabilities _____

PAYMENT IS DUE AT TIME OF SERVICE

I affirm that the Informatlon I have given Is correct to the best of my knowledge. It will be held In the strictest confidence and It Is my responsibility to inform this office of any changes In my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be _____ signature _____ Date _____

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Hunt all insurance benefits otherwise payable to me, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my Insurance does not cover. I hereby authorize Dr. Hunt to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____ Date _____

HH Update _____ Date _____ Initials _____
HH Update _____ Date _____ Initials _____
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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____

Street Address _____ City _____ State ____ Zip _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature _____ Date _____

For office use only

We were unable to obtain a written Acknowledgement of Receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed and a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

Prepared By _____

Signature _____

Date _____

Authorization for Release of Information - Compound Release

Name of Patient _____ Date of Birth _____

Hunt Smile Design is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released**. Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail - number _____	❑ Results of lab tests/x-rays ❑ Other _____
❑ Other person - name _____ Phone number _____	❑ Financial ❑ Medical
❑ Email communication - Provide email address* _____ *For email communication to occur, please accept the disclosure below	❑ Financial ❑ Medical ❑ Appointment reminders ❑ Breach notification
❑ Text communication - Provide number* _____	❑ Appointment reminder ❑ Other _____
*For text communication to occur, please accept the disclosure below:	
❑ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
❑ Photo of patient received by patient or legal guardian ❑ Photo taken by staff (Example : pre/post procedure) ❑ Other _____	❑ May be posted in office ❑ May be posted on website ❑ Other _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward .
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation):

_____