HAYMARKET
FAMILY & COSMETIC
DENTISTRY, PC

Name_____
Last First MI

Nickname _____ ❑ Male ❑Female

Birth Date_____/_____/_____

SSN_____-_____-_____

Referred by_____

Check box below for preferred method of contact:

❑ Home # (_____)_____

❑ Cell# (_____)_____

❑ Work # (_____)_____

Billing Address _____

_____

City State Zip

Home Address (If billing address is a P.O. Box, you MUST provide a physical address):

_____

_____

City State Zip

Email:_____

Marital Status ❑ Single ❑Married ❑ Separated

❑ Widowed ❑Divorced

Active duty military at this time? ❑Yes ❑No

2. Spouse Information (If Applicable)/ Emergency Contact

Name _____

Work # (_____)_____

Home # (_____)_____

Cell # (_____)_____

Email:_____

Active duty military at this time? ❑Yes ❑No

3. Primary Dental Insurance

Insurance Co. Name_____

Insurance Co. Phone # (_____)_____

Policy #_____ Group #_____

Policy Owner's Name_____

Employer_____

Relationship to patient_____

Policy Owner's Birth date _____/_____/_____

Social Security # _____

4. Secondary Dental Insurance (if applicable)

Insurance Co. Name_____

Insurance Co. Phone # (_____)_____

Policy #_____ Group #_____

Policy Owner's Name_____

Relationship to patient_____

Policy Owner's Birth date _____/_____/_____

Social Security # _____

Policy's Owner's Employer _____

5. Consent

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my dental insurance, address or telephone number. Failure to do so will release Haymarket Family & Cosmetic Dentistry from submitting any past claims on my behalf, and default all balances to my responsibility for immediate payment. I do hereby request and authorize the dental staff to perform necessary dental services, including but not limited to x-rays, panoramic or full-mouth series of x-rays (**if cannot be provided within 3yrs from previous dentist)**, study models, photographs, administration of anesthetics, etc. which are deemed advisable by the doctor. I certify that I and my dependents are covered by the insurance listed above and assign directly to Haymarket Family & Cosmetic Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

X_____ Patient Initials

6. Cancellation Policy

Please note that appointments are made in advance so you may see the doctor or hygienist at your convenience. We understand that you may need to make changes to some appointments and we are happy to assist you. However, we ask that you notify our office 24 hours in advance of your appointment to avoid an **$85** fee for appointments that are cancelled or missed after the 24 hour period.

X_____ Patient Initials

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7. Health/Dental History

Physician_____ Phone (___)_____

Previous Dentist_____

Phone(_____)_____

Are you under the care of a physician? ❑Yes ❑No

Ever been hospitalized / surgery? ❑ Yes ❑No

If so, please list_____

_____

Are you allergic to: ❑Latex ❑ Penicillin ❑ Codeine ❑Amoxicillin ❑ Dental Anesthesia ❑Sulfa ❑Other(s):

_____

Please list all medications and dosage you are currently taking:_____

_____

_____

Do you require pre medication before dental treatment?

____ Yes ____No

Reason for today's visit: _____

Date of last dental exam/cleaning: _____

Date of last dental x-rays**:** _____

If you could change anything about your smile, what would it be? _____

Have you ever had any of the following problems?

Please check all that apply:

❑No Known Health Conditions

❑Pacemaker	❑Respiratory Problems
❑Asthma	❑Blood Transfusion(s)
❑Leukemia/Anemia	❑Diabetes/Hypoglycemia
❑Hemophilia	❑Abnormal Bleeding
❑High/Low Blood Pressure	❑Hepatitis A/B/C
❑Liver/Kidney Problems	❑Cancer/Tumors
❑HIV/AIDS/ARC	❑Tuberculosis TB
❑Psychiatric Problems	❑Epilepsy
❑Fainting/Seizures	❑Cerebral Palsy
❑Heart Murmur	❑Rheumatic Fever
❑Congenital Heart Defect	❑Artificial Heart Valve
❑Heart Trouble	❑Crohn's Disease
❑Mitral Valve Prolapse	❑Learning Disability
❑Alcohol/Chemical Dependency	❑Stroke

❑Hip/Knee/or any total orthopedic joint replacement

If so when:_____

❑Pregnant/Nursing- If so how far along?_____

Please relate any other significant medical problems you have not listed above:_____

_____

Check if you have had any of the following:

❑ Bad Breath	❑ Broken Tooth/Filling	❑ Orthodontic treatment
❑ Bleeding Gums	❑ Dental Implant (s)	❑ Ulcer (s)/ Cold Sore (s)
❑ Periodontal Treatment	❑ Food Collection between Teeth	❑ Removable Appliance
❑ Oral Surgery	❑ Smoke Cigarettes/ Smokeless/ E-Cigarettes	
❑ Dry Mouth	❑ Sensitivity to Hot/ Cold/ Sweet/ Pressure	
❑ Grinding/Clenching	❑ Clicking or Popping Jaw	

How often do you brush? _____ Floss? _____ Type of toothbrush? _____

Patient/Guardian Signature_____Date_____

Office Use Only:
Reviewing Doctors Signature:_____ Date_____

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8. HIPAA

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to provide and coordinate treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly and to conduct normal healthcare operations such as quality assessment and improvement activities. Haymarket Family & Cosmetic Dentistry may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining benefits or the benefits payable for related services. I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my dental protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that I may contact this office to obtain a current copy of the *Notice of Privacy Practices.*

I authorize Haymarket Family & Cosmetic Dentistry to disclose my personal information including account balances, diagnosis, treatment and appointment information to the following persons named below. I also authorize Haymarket Family & Cosmetic Dentistry to leave voicemail messages on the phone numbers I have provided to them which may include appointment or account information. I understand I can change this authorization at any point in time, in writing.

_____ _____
Name Relationship

_____ _____
Name Relationship

I certify that all information on this form is true and accurate according to my knowledge.

Patient/Guardian Signature_____Date_____

Office Use Only:
Reviewing Doctors Signature:_____ Date_____

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