HOOD DENTAL CARE

New Patient Registration

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Date Of Birth _____ Age _____ Email Adress _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security # _____ Driver's License # _____

Address _____

City _____ State _____ Zip Code _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer _____ Employer Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

How Did You Hear About Us?

☐ Insurance Provider List ☐ Google / Internet ☐ Our Website ☐ Flyer ☐ Another Dr
☐ Welcome to the Neighborhood Letter ☐ Sign in front Office ☐ T.V. Commercial
☐ Family/Friend: Whom can we thank for referring you? _____

Insurance

Primary Insurance

Subscriber _____

Relationship to Patient _____ Date of Birth _____

Employer _____

Work Phone _____ SSN _____

Insurance Company _____

Ins. Phone # _____ Group # _____

*Hood Dental Care will file dental claims with primary insurance as a courtesy. Filing dental claims with secondary insurance is the responsibility of the patient.

Dental History

What is the reason for your visit today? _____

Date of Last Dental Visit: _____ Last Dental Cleaning: _____ Previous Dentist: _____

How Often Do You Brush Your Teeth? _____ How Often Do You Floss Your Teeth? _____

Are You Happy with the Appearance of Your Teeth? ☐ Yes ☐ No

Is There Anything About Your Smile You Would Like to Change? (Shape, Color, Alignment) If so, Explain:

_____

Are You Extremely Fearful of the Dentist? ☐ Yes ☐ No

If You Need Any Dental Work, Would You be Interested in Being IV Sedated for Your Procedure?

☐ Yes ☐ No

Medical History

Have You Ever Been Told to Take an Antibiotic Prior to Dental Treatment? ☐ Yes ☐ No

If Yes, Then Please List the Reason Why: _____

Have You Had an Orthopedic Total Joint (Hip, Knee, Elbow, Finger) Replacement? ☐ Yes ☐ No

Date: _____ If Yes, Have You Had Any Complications? _____

Are You Allergic To or Have You Had a Reaction To:

Local Anesthetics	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Penicilllin or Other Antibiotics	☐ Yes	☐ No	Metals	☐ Yes	☐ No
Latex (Rubber)	☐ Yes	☐ No	Iodine	☐ Yes	☐ No
Sulpha Drugs	☐ Yes	☐ No	Other: _____		

Have You Ever Taken Any Bisphosphonate Medications such as: Alendronate (Fosamax), Risedronate (Actonel), Denosumab (Prolia) or Boniva for Osteoporosis or Paget's Disease? ☐ Yes ☐ No

Since 2001, Were You Treated or are You Presently Scheduled to Begin Treatment With the Intravenous Bisphosphonates (Aredia or Zometa) for Bone Pain, Hypercalcemia, or Skeletal Complications Resulting from Paget's Disease, Multiple Myeloma, or Metastatic Cancer? ☐ Yes ☐ No

Have You Ever Had Excessive Bleeding Requiring Special Treatment? ☐ Yes ☐ No

Are You Currently Taking or Have You Ever Taken Blood Thinner Medication? ☐ Yes ☐ No

CIRCLE any of the following that apply in either PAST or PRESENT: *Notate if past*

AIDS/HIV Positive(Circle)	Excessive Bleeding	Mitral Valve Prolapse
Alzheimer's Disease	Excessive Thirst	Osteoporosis
Anemia	Fainting/Dizzy Spells	Parathyroid Disease
Angina (chest pain)	Family History Cardiac Disease	Psychiatric Care
Arthritis/Gout	Frequent cough	Radiation Treatments
Artificial Heart Valve	Frequent headaches	Recreational Drug Use
Artificial Joint	Glaucoma	Renal Dialysis
Asthma	Hay Fever	Rheumatic Fever
Blood Disease	Heart Attack/Failure	Rheumatism
Blood Transfusion	Heart Murmur	Scarlet Fever
Breathing Problems	Heart Pacemaker	Shingles
Bruise Easily	Heart Surgery	Shortness of Breath
Cancer/Leukemia	Heart Trouble/Disease	Sickle Cell Disease
Chemotherapy	Hemophilia	Sinus Trouble
Cold Sores/Fever Blisters	Hepatitis A,B,C (Circle type)	Spina Bifida
Congenital Heart Disorders	Herpes	Stomach/Intestinal Disease
Convulsions	High Blood Pressure	Stroke
Cortisone Medication	High Cholesterol	Swelling of Limbs
Diabetes	Hives/Rashes	Thyroid Disease
Drug Addiction	Hypoglycemia	Tonsillitis
Eating Disorder	Irregular Heartbeat	Treatment
Emphysema	Kidney Trouble	Tuberculosis (TB)
Epilepsy/Seizures	Liver Disease Lung Disease	Tumors
Excessive Bleeding	Low Blood Pressure	Ulcers

Do You Have Any Disease, Condition, or Problem not Listed? _____

_____

_____

Medical History Cont.

PLEASE LIST ALL Pills, Medications, or Drugs You Are Currently Taking: _____

_____

_____

_____

_____

_____

Are You Currently Under a Physician's Care? ☐ Yes ☐ No

If Yes, for What Reason? _____

When Was the Last Time You Saw a Medical Physician? _____

Have You Ever Been Hospitalized or had a Major Operation? ☐ Yes ☐ No

If Yes, for What Reason? _____

Do You Smoke or Use Tobacco Products? ☐ Yes ☐ No

WOMEN:

Are You Currently Pregnant? ☐ Yes ☐ No

If Yes, What is Your Due Date & How Many Weeks Along Are You? _____/_____ wks

Are You Currently Nursing? ☐ Yes ☐ No

Authorization

I certify that the above information is accurate to the best of my knowledge, and that I agree to be treated by Dr. Hood, his associates and the Hood Dental Care staff. I further understand that payment is due at the time of service, and should it become necessary, any attorney fees, court costs, and collection fees become my responsibility and will be added to my account.

I certify that I, and/or my dependent(s), have insurance coverage as described and assign directly to Hood Dental Care, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I have read a copy of this office's privacy practices, made available upon request.

Print Name _____ Date ___/___/___

Signature_____

HOOD
DENTAL CARE

Committed to Excellence in Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of [Hood Dental Care]'s Notice of Privacy Practices, which has an effective date of 09/23/13, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____

Signature of Patient or Patient's Representative

_____

Date

_____

Print Name

_____

Relationship to Patient (If not signed by the Patient)

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CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT FOR RECEIPT OF INFORMATION

State law requires us to obtain your consent for the contemplated dental treatment. What you are being asked to sign is confirmation that we have discussed the nature purpose of your contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

Including any necessary or advisable anesthesia.

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:

Alternative to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

RISKS ASSOCIATED WITH RECOMMENDED DENTAL TREATMENT:

I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A partial listing of the risks known to be associated with this treatment and with the associated anesthetic are:

- Change of Bite
- Loss of Taste
- Swallowing of Objects
- Drug/Allergic Reaction
- Dry Socket
- Infection
- Breakage of Roots
- Retained Root Fragments
- Loss / Damage to Adjacent Teeth & Bone
- Fracture or Breakage of Jaw
- Sinus Involvement
- Further Surgery or Treatment
- Pain
- Instrument Breakage
- Trismus (Jaw Pain or Difficulty Opening Mouth
- Swelling & Bruising Which May Necessitate Staying Home for Several Days
- Retained Instrument Fragments
- Paresthesia (Permanent or Transient Numbness of the Cheeks, Gums, Teeth, Lips, Tongue, Chin & Face)
- Stretching of the Mouth Which May Result in Cracking or Bruising
- Failure of the Treatment to Accomplish it's Purpose
- Bleeding Which May be Heavy Enough to Stop Procedure
- TMJ Dysfunction or Worsening of TMJ Conditions

State law requires that we specifically advise you that, although rarely occurring, the dental treatment of anesthetic may result it: Death, Brain Damage, Quadriplegia, Paraplegia, Loss of Organ(s), Loss of Function of Face, Arm(s), or Leg(s) and Disfiguring Scars.

Please flip to next page to sign for the acknowledgement of this consent.

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ACKNOWLEDGEMENT

I acknowledge that I have read and understand the information on both pages of this consent form (or that it has been read to me). I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about the treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand that the success of this treatment and the avoidance of treatment complications depends to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me, my following of them, and keeping the appointments for the treatment follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complication(s), where further treatment may be discussed, or administered, which I not currently anticipated.

I hereby authorize and direct E. Edward Hood, Jr., D.D.S. and/or associates or assistants of his or her choice, to perform the diagnostic, surgical, or dental treatments. This consent form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive any further disclosures or information.

Date _____

Signature of Patient _____

Signature of Relative (if required) _____

Signature of Witness _____

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AUTHORIZATION AND RELEASE

I, _____ do hereby authorize and release to the following: diagnosis, dental findings, information including, but not limited to the following: diagnosis, dental findings and procedures, radiographs, images, photographs, diagnostic models and additional materials.
In consideration of such disclosure on the part of the above named person of institutions, I hereby release them from any and all liability arising from such disclosures.

Patient Signature _____ Date_____

Witness Signature _____ Date_____

YOUR DENTAL INSURANCE IS YOUR RESPONSIBILITY...BUT WE CAN HELP.....regardless of what we might calculate as your dental benefit in dollars. We must stress the fact that you, the patient, are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. Our estimate is based on limited information obtained from your insurance company. We allow 45 days for your insurance company to make payment. AFTER THIS TIME ALL INQUIRES (FOLLOW UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

Patient Signature _____ Date_____

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PATIENT AGREEMENT

Please initial and sign

_____ As a courtesy to our patients using insurance; we are happy to file primary claims. All benefits quoted are estimates only and not a guarantee of payment. If you have questions regarding your coverage, please contact your insurance company directly.

_____ If insurance coverage is terminated or has not been updated with Hood Dental Care; the patient will be responsible for all incurred charges.

_____ Hood Dental Care provides the most up to date services. These services include, but are not limited to, composite (tooth colored fillings), same day crowns and cosmetic dentistry. Insurance companies may not cover all procedures. In these cases, the patient will be responsible for any unpaid balances.

_____ Treatment plans and associated fees may change without notice if it is in the best interest of the patient at the time of treatment.

_____ All estimated fees are due at the time of treatment. We are happy to discuss finance options. All financial arrangements must be made before any treatment is rendered.

_____ Appointments that are over 90 minutes require a 50% deposit prior to scheduling.

_____ After ninety days, all outstanding balances will be forwarded to our collection agency.

_____ One American dies every hour due to oral cancer. For this reason; we conduct an oral cancer screening once per year starting at the second scheduled exam. If your dental insurance does not cover this procedure; the patient will be billed $40.00.

_____ I authorize and give consent to Hood Dental Care to perform the dental services agreed between doctor and patient or parent/guardian to be necessary and advisable including the use of local anesthesia and other medications as indicated.

I understand that I am ultimately responsible for all services rendered. In the case of default, I am responsible for the cost of attorney's fees, court costs, the cost of collection proceedings and I waive the right to have any amounts owed discharged in bankruptcy.

Patient Signature _____ Date_____