WELCOME TO OUR PRACTICE

PATIENT INFORMATION

__Mr. __Mrs .__Ms. __Dr. First Name _____ M.I. ___ Last Name_____ Nickname_____

Sex: __Male __Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ _____City _____ State _____ Zip Code _____

Home Phone (___)_____Cell Phone (___) _____ Have you ever been a patient of our practice? ___Yes ___ No

Medical Doctor _____ Phone (____) _____ Marital Status ____ Spouse's Name _____

Employer _____ Bus Phone (____) _____

PAYMENT AND INSURANCE INFORMATION

Who will be responsible for this account? ____Self ____Spouse ____ Father ____ Mother ____Other _____
(If self, skip to next section)

First Name _____ Last Name _____ S.S. # _____ Phone_____

Street _____ City _____ State _____ Zip Code _____

Employer _____ Bus. Phone (____) _____

Student: ____ Full Time ____Part Time ____ School Name _____

____ Married ____Divorced ____Legally Separated ____Widow ____Single

Employed: ____Full Time ____Part Time ____Retired ____Homemaker

PRIMARY DENTAL INSURANCE COMPANY

Employer _____ Bus. Address _____
Bus. Phone (____) _____ _____
Ins. Co. Name _____ Bus. Address _____
Bus. Phone (____) _____ _____
Group # _____ Group Name _____
Insured Party _____ Relationship to insured _____ Birth Date _____ S.S.# _____
Address _____ Phone (____) _____ I.D.# _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____ Bus. Address _____
Bus. Phone (____) _____ _____
Ins. Co. Name _____ Bus. Address _____
Bus. Phone (____) _____ _____
Group # _____ Group Name _____
Insured Party _____ Relationship to insured _____ Birth Date _____ S.S.# _____
Address _____ Phone (____) _____ I.D.# _____

DENTAL HISTORY

Date of last dental visit _____
Name of previous dentist _____ Phone (____) _____

HEALTH HISTORY

To our family of patients: Although dentists primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you are taking have an important interrelationship with the dental care you will be receiving. There is a serious relationship between periodontal (gum) problems and heart disease. Thank you for answering the following questions. Your answers are for our records and will be considered confidential.

Reason for today's office visit. _____

	Yes	No
01. Have you had any changes in your general health in the past year? ----------	____	____
02. Are you under the care of a physician? ____ Date of last visit _____	____	____
If so, for what are you being treated? _____		
03. Have you had any illness, surgery or been hospitalized in the past five years? ----------	____	____
If so, describe _____		
_____		
04. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ____ *If so, describe where* _____	____	____
05. Do you have a prosthetic joint/implant? ____ *If so, describe where* _____	____	____
06. Have you had a heart valve replacement or vascular graft? ----------	____	____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	NOTES
07 Rheumatic Fever?			
08 Damaged heart valves?			
09 Mitral valve prolapse?			
10 Heart Murmer			
11 High blood pressure?			
12 Low blood pressure?			
13 Chest pain / angina?			
14 Heart attack(s)?			
15 Irregular heart beat?			
16 Cardiac pacemaker?			
17 Heart surgery?			
18 Bronchitis, chronic cough?			
19 Asthma?			
20 Hay fever / sinus problems?			
21 Snoring / sleep apnea?			
22 Difficulty breathing / lung trouble?			
23 Tuberculosis?			
24 Emphysema?			
25 Do you smoke?			
26 Do you use chewing tobacco?			
27 Blood transfusion?			
28 Blood disorder such as anemia?			
29 Bruise easily?			
30 Abnormal bleeding?			
31 Hepatitis, jaundice, or liver disease?			
32 Infectious mononucleosis?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	NOTES
33 Gallbladder trouble?			
34 Fainting spells?			
35 Convulsions / epilepsy?			
36 Stroke?			
37 Thyroid trouble?			
38 Diabetes?			
39 Low blood sugar?			
40 Kidney trouble?			
41 Are you on dialysis?			
42 Swollen ankles, arthritis?			
43 Stomach ulcers?			
44 Contagious disease?			
45 Sexually transmitted disease?			
46 Problems with the immune system?			
47 Delay in healing?			
48 A tumor or growth?			
49 Radiation / chemotherapy?			
50 Chronic fatigue / night sweats?			
51 Are you on a diet?			
52 A history of drug abuse?			
53 A history of alcohol abuse?			
54 Contact lenses?			
55 Eye disease / glaucoma?			
56 Mental health problems?			
57 A removable dental appliance?			
58 Pain & clicking of jaws when eating?			

MEDICATION – Are you now taking or have taken...	*Yes*	*No*	*NOTES*
59 Any kind of medication, drugs, pills?			
60 Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)?			
61 Have you ever taken diet pills?			
62 Any natural product, herbal supplement or homeopathic remedy?			
63 Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			
64 Have you ever taken tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:			
65 Please list any medications you are currently taking:			

ALLERGIES – Are you allergic to, or had a reaction to...	*Yes*	*No*	*NOTES*
66 Local Anesthetic (numbing med.)?			
67 Penicillin?			
68 Other antibiotics?			
69 Sulfa Drugs?			
70 Sodium pentothal, Valium, or other tranquilizers?			
71 Aspirin?			
72 Codeine or other narcotics?			
73 Other medications?			
74 Latex?			
75 Soy?			
76 Eggs / Yolks?			
77 Sulfites?			
78 Please list any allergies other than drug allergies:			

This Section Is For Women Only.

78 Is there a possibility of pregnancy? ____ Yes ___ No
79 Expected delivery date _____
80 Are you nursing?---------- ____ Yes ___ No
81 Are you taking birth control pills? ____ Yes ___ No

Women Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.*

IS THIS VISIT RELATED TO AN ACCIDENT?

Automobile ___yes ___no
Work Related ___ yes ___no
Date of Injury _____ **Other** ___ yes ___ no

Insurance Company handling this claim _____
Claim Number _____
Name of Attorney / Adjuster _____
Tel. (___) _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Tel. (___) _____ Bus Tel. (___) _____

FEES AND PAYMENTS

We make every effort to keep down the cost or your oral healthcare. You can help by paying with cash, check or credit card at the time of service. Other payment options available on a case by case basis including automatic draft of a checking or savings account and pre-payment of dental fees. Please see our Financial Coordinator for details.

An estimate of the charges for any procedure you may require will be given to you upon request. If you have any dental insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductable amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs.

This signature on file is your authorization for the release of information necessary to process your claim.

Hounshell Family Dentistry
209-B Patton Drive
Shelby, NC 28150

I hereby acknowledge that a copy of this office's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.
Signature of Patient: (Parent or guardian if minor) **X**_____

Date:_____

A Treatment Plan will be presented to you when treatment is recommended by the dentist including proposed treatment, treatment fees and **ESTIMATED** insurance coverage. If you have dental insurance, we will be glad to file a claim on your behalf. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay the deductible amount and co-insurance at the time of service. You will be responsible for any balance not paid for by your insurance company. You will be responsible for all collection costs. It is your responsibility to inform your provider of any insurance or Medicaid changes or terminations. If you fail to do so, you are responsible for the balance of services rendered that day.**

I certify that I have read and understand the statements above. I have been given the opportunity to ask questions regarding these statements.
Signature of Patient: (Parent or guardian if minor) **X**_____

Date:_____

I hereby acknowledge authorize the release of information necessary to process a claim to my insurance provider.
Signature of Patient: (Parent or guardian if minor) **X**_____

Date:_____

Dentistry is not an exact science and reputable practitioners cannot properly guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination, but were found during the course of treatment. Any change in treatment plan may result in additional fees. Guarantees and assurances cannot be made by anyone regarding dental treatment. It is essential that you keep your appointments and cooperate in your treatment to help insure the best possible result.

I certify that I have read and understand the statements above. I have been given the opportunity to ask questions regarding these statements.
Signature of Patient: (Parent or guardian if minor) **X**_____

Date:_____

Hounshell Family Dentistry

209 Patton Drive, Suite B
Shelby, NC 28150
704-482-7739
www.myshelbydentist.com

Authorization for Release of Information

Name of Patient _____ DOB _____

Hounshell Family Dentistry, Brandon C. Hounshell, DDS PA, is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the spouse, parent or others in keeping with the patient's instructions.

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 of the left in the same section.
○ Voice Mail: Name Phone	○ Results of Lab Tests/X-rays ○ Other
○ Spouse:	○ Family Billing Information ○ Financial ○ Medical as Follows:
○ Parent: (provide name)	○ Family Billing Information ○ Financial ○ Medical as Follows:
HOUNSHELL FAMILY DENTISTRY 209-B PATTON DRIVE SHELBY, NC 28150	○ Family Billing Information ○ Financial ○ Medical as Follows:

Rights of Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to ***Hounshell Family Dentistry, Brandon C. Hounshell, DDS PA.*** I understand that a revocation is not effective in cases where the information has already been disclosed by Hounshell Family Dentistry, Brandon C. Hounshell, DDS PA, and will be effective going forward from the date of revocation.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked in writing by the patient.

_____ _____

Signature of Patient or Personal Representative *Date*