HAMPTON DENTAL

Patient Welcome Form

Patient Information

Adult/Child: ______________________ Date: ______________________

Last Name: ______________________ First Name: ______________________ MI: __________

Gender: ☐ Male ☐ Female Email: ______________________ Birthdate: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower

Driver's License #: ______________________ S.S.# ______________________

Address: ______________________ Apt./Condo #: ______________________

City: ______________________ State: ______________________ Zip Code: ______________________

Home Phone: ______________________ Mobile Phone: ______________________

Occupation: ______________________ Work Phone: ______________________

Guarantor

If the patient is a minor, do you have legal custody? ______________________

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Tutor ☐ Legal Guardian ☐ Other

Last Name: ______________________ First Name: ______________________ MI: __________

Gender: ☐ Male ☐ Female Email: ______________________ Birthdate: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower

Driver's License #: ______________________ S.S.# ______________________

Address: ______________________ Apt./Condo #: ______________________

City: ______________________ State: ______________________ Zip Code: ______________________

Home Phone: ______________________ Mobile Phone: ______________________

Occupation: ______________________ Work Phone: ______________________

When is the best time to contact you? ______________________

Emergency Contact:

In case of emergency please provide the following information:

Name: ______________________ Relationship: ______________________

Work Phone: ______________________ Home/Mobile Phone: ______________________

How did you hear about us?

☐ Family/Friend
☐ Event
☐ My Insurance Plan
☐ Google
☐ Yelp
☐ Facebook
☐ Instagram
☐ Flyer/Mail
☐ Outside Sign
Walk-In
Other

Payment Options:

☐ Insurance
☐ Credit Card
☐ Cash/Check
☐ Debit Card
☐ I am interested in financing

Dental History:

Why have you come to the dentist today?: ____________________

Are you currently in pain? (Yes/No): ____________________

Have you ever had a problem with any previous dental work? (Yes/No): ____________________

Do your gums bleed? (Yes/No): ____________________

How many times a week do you brush?: ____________________

How many times a week do you floss?: ____________________

Medical History:

Personal Physicians Name: ____________________ Phone Number: ____________________

Date of Last Visit: ____________________ Your current health is (Good/Regular/Poor): ____________________

Are you currently under the care of a physician? (Yes/No): ____________________

Please explain: ____________________

Are you taking any prescription/over the counter drugs? (Yes/No): ____________________

Please list each one: ____________________

Do you smoke tobacco in any way? (Yes/No) ____________________

<u>Do you have or have you ever had any of the following?</u>

Please select all that apply:

- □ Abnormal Bleeding
- □ AIDS, HIV+
- □ Alcohol or Drug Abuse
- □ Anemia
- □ Arthritis
- □ Artificial Bones/Joints/Valves
- □ Asthma
- □ Blood Transfusion
- □ Cancer Chemotherapy
- □ Colitis
- □ Congenital Heart Defect
- □ Diabetes
- □ Difficulty Breathing
- □ Epilepsy
- □ Fainting Spells
- □ Frequent Headaches
- □ Glaucoma
- □ Hay Fever
- □ Heart Attack
- □ Heart Surgery
- □ Heart Murmur
- □ Hemophilia
- □ Hepatitis B/C
- □ Herpes, Fever Blisters
- □ High Blood Pressure
- □ Kidney Problems
- □ Liver Disease
- □ Low Blood Pressure
- □ Lupus
- □ Mitral Valveprolapse
- □ Pacemaker
- □ Psychiatric Problems
- □ Radiation Treatment
- □ Rheumatic; Scarlet Fever
- □ Seizures C Shingles
- □ Sickle Cell Disease
- □ Sinus Problems
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Ulcers

Are you allergic to any of the following?

Please select all that apply:

- □ Aspirin
- □ Codeine
- □ Dental Anesthetics
- □ Penicillin
- □ Erythromycin
- □ Latex
- □ Jewelry
- □ Tetracycline

For women:

Are you taking birth control pills? ____________________

Are you pregnant?: ____________________

Week #: ____________________

Are you nursing?: ____________________

GENERAL DENTISTRY INFORMED CONSENT

Dentist: ____ Patient: ____

1. **WORK TO BE DONE:** I understand that I am having the following work done: □ Fillings, □ Bridges, □ Crowns, □ X-rays, □ Extractions, Impacted teeth removed, □ Root Canals, □ Dentures, □ Other ____________________________ (Initials ___________)
2. **DRUGS AND MEDICATION:** I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. (Initials ___________)
3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination: For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. (Initials ___________)
4. **REMOVAL OF TEETH:** Alternatives to removal have been explained to me (root canal therapy, crowns; periodontal surgery, etc.) And I authorize the dentist to remove the following teeth: ____________________________ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it maybe necessary to have future treatment. I *understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility. (Initials ___________)
5. **CROWNS, BRIDGES, AND CAPS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come of easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my news crown bridge, or tap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days 'Earn tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crow, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation. (Initials ___________)
6. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. (Initials ___________)
7. **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that I have a serious condition, causing gum and bone inflammation or loss and-that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition, (Initials ___________)
8. **FILLINGS:** I understand that care must be exercising in chewing on Hines especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials ___________)
9. **DENTURES:** I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of 30 days, there will be additional charges. (Initials ___________)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guar antes or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees. I agree to pay any attorney's fees, or court costs, that may be incurred to satisfy this obligation.

Signature of Patient: ____ Date: ____________________________

Signature of Dentist: ____ Date: ____________________________

Agreement:

I acknowledge that this information is correct and will be held in the strictest confidence.
I authorize Hampton Dental to contact me regarding promotions and services.
I authorize Hampton Dental to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Hampton Dental of the group insurance benefits otherwise payable to me. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature:____ Date: _________________________

Office Use Only:

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: __________________ Date: _________________
Doctor's Comments: ____

UPDATE:
Comment: ____
Signature: ____ Date: __________________________

<u>Acknowledgment of Receipt of Notice of Privacy Practices</u>

Patient Acknowledgment of the Notice of Privacy Practices and Consent for Use and Disclosure of Personal Health Information

I, ________________________, acknowledge that I have either received a copy of this office's Notice of Privacy Practices or that this office's Notice of Privacy Practices was made available to me to receive.

I, ________________________, consent to the use and disclosure of my personal health information by your office for Treatment, Billing/Payment, and Health Care Operations as outlined in the Notice of Privacy Practices.

Print Name:______________________________________ Signature:______________________________ Date: _________