Hobbs Family Dental Care

Thank you for selecting Hobbs Family Dental Care and our dental health care team. Our primary mission is to assist each patient in keeping all of their teeth for their lifetime by delivering the best comprehensive dental care available. To help us meet all your dental care needs, please fill out this form completely. Please print and use ink. If you have any questions or need assistance, please ask us. We will be happy to assist you.

PATIENT INFORMATION

Full Name: _____ Date: _____

Gender: ☐ Male ☐ Female Status: ☐ Single ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Nickname: _____ Spouse's Name: _____

Birth Date: _____ Social Sec. #: _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone _____ Cell _____

Work Phone _____ Email address _____

Employer: _____ Occupation: _____

Referred By: □ Television commercial □ Insurance □ Billboard □ Yellow pages □ Internet
□ Person _____ □ Other _____

RESPONSIBLE PARTY INFORMATION FOR THIS PATIENT – *COMPLETE ONLY IF DIFFERENT FROM PATIENT*

Name: _____ Relationship to Patient: _____

Birth Date: _____ Driver's Lic. #: _____ Soc. Sec. #: _____

Address: _____

City: _____ State _____ Zip: _____

Employer: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Ext. _____

Cell Phone: _____ Prefer Calls: ☐ Home ☐ Work ☐ Cell

_____ _____
Signature of responsible party Date

In Case of Emergency:

Contact Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance: Policy Holder Information
Policy Holder Name _____
Relationship to Patient: _____
Date of Birth: _____ Soc. Sec. #: _____
Insurance Company: _____
Ins. Co. Address: _____
Group #/Contract #: _____
Employee Name _____

❖ Policies Regarding Patient Insurance

Insurance plans are payment assistance plans; they are not designed to cover the entire cost of treatment. Your insurance benefits are a contract between you, your insurance company and your employer (if this is an employer plan). The amount of coverage you receive will depend on the quality of the plan purchased by you and your employer (if applicable). Insurance companies sell a wide variety of plans and each plan has different rules, plan limitations and exclusions determined by the insurance company and your employer (if applicable) that our office may not be informed of when we check your benefits with your insurance company. It is our responsibility to provide you with treatment that best meets your personal needs, not to match your care to your insurance plans covered benefits or plan limitations.

As a courtesy, we will bill your insurance benefits from your insurance carrier for the portion covered by your policy once your plan is verified. Our office will estimate your insurance benefits and your co-payment for each appointment. Your co-payment is calculated on the information provided by your carrier at the time of estimate. While we can generally estimate benefits with reasonable accuracy, *we emphasize this is an estimate ONLY* based on information received from your insurance company. When your insurance company provides this benefit information, they preface it with the disclaimer, "**this is not a GUARANTEE of coverage as actual benefit payments are determined only when a claim is processed.",** therefore, we CANNOT be held responsible to any estimate in any way. **PLEASE NOTE: We are only in network with Delta Dental and we do not bill secondary Insurance.**

- **I understand my estimated co-insurance portion, including any deductible, will be collected at the time of service.**
- **I understand any claim not paid by the insurance carrier within 60 days will be billed to me, the patient or responsible party, for immediate payment. The patient or responsible party will need to contact and collect any benefits directly from the insurance company.**
- **In the event I receive the assigned payment for treatment directly from insurance, it is my responsibility to endorse the check and forward immediately to Hobbs Family Dental Care**
- **All charges not paid by my insurance company are my responsibility regardless of the reason for nonpayment for myself and/or my dependents**.

- (Initial) _____

Insurance Signature Authorization

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me and my Dependent and/or other health practitioners relating to all claims for benefits submitted on behalf of myself/and or my dependents. I agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim submitted for myself and/or my dependents. I will be bound by this signature as though I had personally signed each claim. I hereby assign all medical, dental, and/or surgical benefits to which I am entitled for this service to Hobbs Family Dental Care. A photocopy of this assignment is to be considered as valid as an original.

Signature of Patient or Parent/Guardian of Minor	Signature of Co-Responsible Party	Date

MEDICAL HISTORY

Although dentistry treats primarily the area in and around your mouth, your mouth is a part of your entire body. Therefore, other health problems or medications that you may be taking could be relevant to your dental care. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No
Have you ever been hospitalized for a major operation? ☐ Yes ☐ No
Have you ever had a serious head/neck injury? ☐ Yes ☐ No
Are you taking any medications, vitamins, pills, or drugs? ☐ Yes ☐ No If yes, please list:_____

_____

_____

Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women
Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking Oral Contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Local Anesthetics

Other, please explain:_____

Do you have, or have you ever had, any of the following (please check all that apply)?

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valves
Placed When? _____
Physician_____
☐ Artificial Joint(s)
Placed When?_____
Body Location_____
Physician_____
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Cancer
When_____
Type_____
☐ Chemotherapy
☐ Chemical Dependency
☐ Circulatory Problems
☐ Congenital Heart Disorder

☐ Convulsions
☐ Cortisone Treatments
☐ Cough, persistent
☐ Cough up blood
☐ Diabetes
*Baseline blood glucose level
_____
☐ Emphysema
☐ Epilepsy or seizures
☐ Excessive Bleeding
☐ Fainting Spells/Dizziness
☐ Frequent Headaches
☐ Glaucoma
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Heart Problems
*Describe_____
_____
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes
☐ High Blood Pressure
*Baseline BP _____

☐ Jaw Joint Pain
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatments
When _____
Location_____
☐ Renal Disease
☐ Respitory Disease
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shortness of Breath
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Skin Rash
☐ Stomach/Intestinal Disease

☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice
☐ Other
_____
_____
_____
_____

Have you ever had a serious illness not listed above? ☐ Yes ☐ No If YES, please explain: _____
_____
_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information may be dangerous to my (or the patient's) health. I understand that it is my responsibility to inform the dental office promptly of any changes in overall health or medical status.
Signature of Patient, Parent, or Guardian_____Date_____

MEDICAL HISTORY

Reason for visit today? _____

Date of: Last Dental Visit _____ Last Dental Cleaning _____ Last Dental X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____ Phone: _____

Address: _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What dental aids do you use? (Proxybrush, rinses, etc.) _____

Are any of your teeth sensitive to:
Hot or cold? ☐ Yes ☐ No
Sweets? ☐ Yes ☐ No
Biting or chewing? ☐ Yes ☐ No

Do you notice any mouth odor or bad taste? ☐ Yes ☐ No

Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to become caught in your teeth?
If yes, where _____ ☐ Yes ☐ No

Do you:
Clench or grind your teeth while awake? ☐ Yes ☐ No
Clench or grind your teeth while you sleep? ☐ Yes ☐ No
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ☐ Yes ☐ No
Mouth breathe while awake or asleep? ☐ Yes ☐ No
Have tired jaws, especially in the morning? ☐ Yes ☐ No

Have you ever had:
Orthodontic treatment? ☐ Yes ☐ No
Oral Surgery? ☐ Yes ☐ No
Periodontal treatment? ☐ Yes ☐ No

Your teeth ground or the bite adjusted? ☐ Yes ☐ No
A bite plate or mouth guard? ☐ Yes ☐ No
A serious injury to the mouth? ☐ Yes ☐ No
If yes, describe _____

Have you ever experienced:
Clicking or popping of the jaw? ☐ Yes ☐ No
Joint, ear or side of face pain? ☐ Yes ☐ No
Difficulty in closing mouth? ☐ Yes ☐ No
Headaches, neck aches or shoulder aches? ☐ Yes ☐ No
Sore muscles? (neck or shoulders) ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No
Would you like to keep all of your teeth, all of your life? ☐ Yes ☐ No

I have a ☐ low ☐ medium ☐ high fear of going to the dentist.

What is your biggest concern?

_____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No
If so, please describe

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____

_____

FOR OFFICE USE ONLY

Reviewed by: _____ Date: _____
(staff signature)

OFFICE POLICIES AND FINANCIAL AGREEMENT

We believe it is important to share our policies with our patients in advance. Everyone benefits when office and financial policies are understood. As always, we are happy to answer any questions you may have or explain the treatment process in greater detail. Please read thoroughly and sign below indicating that you understand these policies and agree to comply with them. We appreciate the confidence you place in us.

❖ Payment Policy

For patients with insurance: I understand I will be required to pay in full an estimate of any annual deductible(s) and co-payments not payable by my insurance plan(s) at the time of service.[1] **Any remaining balance not paid by my insurance is my responsibility and is due in full immediately upon receipt of the FIRST statement sent.** (Initial) _____

Uninsured patients: I understand payment in full is required at the time of service and agree to pay all charges at the time of my appointment. (Initial) _____

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice. USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. Required by Law: We may use or disclose your health information when we are required to do so by law. Abuse or Neglect: We may disclose your health information to appropriate

[1] However, if payment is not received from your insurance carrier within 60 days, you will be responsible for the immediate payment of your treatment fees, and to collect your benefits directly from your insurance carrier. In the event you receive direct payment from your insurance for treatment, it is your responsibility to endorse the check and forward to Hobbs Family Dental Care.

authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances. Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.00 for each page, $0.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Authorization of phone or mail payments: I authorize Hobbs Family Dental Care to process credit or debit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay these transactions.
(Initial) _____

Statements and Delinquent Accounts Policy

A statement will be sent to you after insurance payment is received for any remaining balance. Payment in full of this remaining balance is due **IMMEDIATELY** upon receipt. If it is necessary to send additional statements due to non-payment after the initial statement, a $5 billing fee will be added to your account for each additional statement.

All accounts over 90 days will be subject to being forwarded to a collection agency for collection and credit reporting. In the event it becomes necessary to use a third party agency to collect any past due balances, I agree to pay any/all collection fees and associated administration fees, reasonable attorney fees, and/or court costs.
(Initial) _____

OFFICE POLICIES AND FINANCIAL AGREEMENT

❖ Cancellation & Late Policy

Our time is valuable and so is yours. Our office does not overbook appointments. Please understand that when you make an appointment with us, your appointment time is reserved for you only. In an effort to continually provide quality service for all patients, we ask that you keep your reserved appointment(s) as scheduled.

Appointments are scheduled by the time necessary to complete the planned treatment. It is extremely important to **arrive on time for your appointment** so treatment can be started and completed on time enabling the next patient to be seen promptly at their appointed time. If you are late for your appointment, we may not be able to accommodate you as it may interfere with the next patient's reserved time. Contact us immediately if you think you will be late so we can advise you if your late arrival can be accommodated or if you will need to reschedule.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies.

I have read, understand, and agree to all Office and Financial Policies, terms and conditions stated in this document.

Signature of Patient or Parent/Guardian of Minor	Signature of Co-Responsible Party	Date

Hobbs Family Dental Care -- Phone: (575) 392-7565 -- Fax: (575) 392-0224
3218 N Grimes, Hobbs, NM 88240
Hours: Monday – Thursday 8 am - 5 pm (closed for lunch 12 - 1 pm)