HANSON DENTAL

Welcome to Hanson Dental!

We are excited to have you as part of our dental practice. We thank you for trusting us with your dental care needs. It is our mission to provide the highest quality dental care to our patients. Our office wants our patients to be able to comfortably afford their dental treatment for teeth, gums, and bones to last a life time. We proudly offer the following practice policies so that our patients can have the opportunity to decide which treatment and payment options will best suit their individual needs. We ask that you please read, agree to, and sign before any treatment is rendered.

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Birth Date: _____ Soc Sec: _____

Responsible Party's Name (if different from above): _____Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Email Address: _____

Soc Sec: _____ Drivers Lic: _____ State Issued: _____

Emergency Contact: _____ Phone: _____

PRIMARY DENTAL INSURANCE

Policy Holder's Name: _____

Policy Holders DOB: _____

Group/Emp Name: _____

Group Number: _____

Insurance Carrier: _____

Member ID or SSN: _____

SECONDARY DENTAL INSURANCE

Policy Holder's Name: _____

Policy Holders DOB: _____

Group/Emp Name: _____

Group Number: _____

Insurance Carrier: _____

Member ID or SSN: _____

Acknowledgement of Receipt of Privacy Practices:

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. Your personal health information will not be shared. I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement; this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Patient/Responsible Party Signature: _____ Date: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? O Yes O No O N/A _____

Have you ever been hospitalized or had a major operation? O Yes O No O N/A _____

Have you ever had a serious head or neck injury? O Yes O No O N/A _____

Are you taking any medications, pills, or drugs? O Yes O No O N/A _____

Do you take, or have you taken, Phen-Fen or Redux? O Yes O No O N/A _____

Do you use tobacco? O Yes O No O N/A _____

Are you on a special diet? O Yes O No O N/A _____

Do you use controlled substances? O Yes O No O N/A _____

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O O Other _____

Women: Are you O Pregnant/Trying to get pregnant? O Nursing? O Taking oral contraceptives?

Do you have, or have you had, any of the following?

O AIDS/HIV Positive
O Alzheimer's Disease
O Anaphylaxis
O Arthritis/Gout
O Artificial Heart Valve
O Artificial Joint
O Asthma
O Blood Disease
O Blood Transfusion
O Breathing Problem
O Bruise Easily
O Cancer
O Chemotherapy
O Chest Pains
O Cold Sores/Fever Blisters
O Congenital Heart Disorder
O Convulsions
O Cortisone Medicine
O Diabetes
O Drug Addiction
O Easily Winded
O Emphysema
O Epilepsy or Seizures
O Excessive Bleeding
O Excessive Thirst
O Fainting Spells/Dizziness
O Frequent Cough
O Frequent Diarrhea
O Frequent Headaches
O Genital Herpes
O Glaucoma
O Hay Fever
O Heart Attack/Failure
O Heart Murmur
O Heart Pacemaker
O Heart Trouble/Disease
O Hemophilia
O Hepatitis A
O Hepatitis B or C
O Herpes
O High Blood Pressure
O High Cholesterol
O Hives or Rash
O Hypoglycemia
O Irregular Heartbeat
O Kidney Problems
O Leukemia
O Liver Disease
O Low Blood Pressure
O Lung Disease
O Mitral Valve Prolapse
O Osteoporosis
O Pain in Jaw Joints
O Parathyroid Disease
O Psychiatric Care
O Radiation Treatments
O Recent Weight Loss
O Renal Dialysis
O Rheumatic Fever
O Rheumatism
O Scarlet Fever
O Shingles
O Sickle Cell Disease
O Sinus Trouble
O Spina Bifida
O Stomach/Intestinal Disease
O Stroke
O Swelling of limbs
O Thyroid Disease
O Tonsillitis
O Tuberculosis
O Tumors or Growths
O Ulcers
O Venereal Disease
O Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No O N/A _____

Additional Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Responsible Party Signature: _____ Date: _____

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OFFICE POLICIES

We proudly offer the following practice policies so that our patients can have the opportunity to decide which treatment and payment options will best suit their individual needs. We ask that you please read, agree to, and sign before any treatment is rendered.

Dental Insurance:
Please be prepared to show your current dental insurance card and a valid photo ID at each visit, or when your insurance coverage changes. Your insurance is a contract between you, your employer (if applicable) and the insurance company. At Hanson Dental, we will file your insurance claim for you. As a courtesy, we will assist you with information, however, if you have any additional questions about coverage, please contact your insurance provider or human resources department.

Please remember that insurance is not deigned to cover 100% of the cost of all types of dental treatment. At the time of treatment, the patient/guarantor is responsible for the estimated portion that the insurance does not cover (also called "copay"). Treatment recommended by our dental professionals is never based on what your insurance company will pay, but on what our team feels is best for your overall dental health. We request that you understand your benefit plan and be familiar with the dental benefits covered by your insurance in advance of your appointment so that together we can make the best treatment decisions for you.

Financial Policies:
Our policy requires payment in full for all services rendered at the time of visit or if insured, co-payment will be due unless other arrangements have been made with our business team. All accounts are due 60 days from the date of service. Balances not cleared within 60 days are subject to a late payment fee of 1.5% per month (minimum of $0.50) of the remaining balance. Accounts that surpass 90 days delinquency will receive a monthly billing charge of $1.00. We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

Appointment Policy:
When you schedule an appointment with our office, our staff takes time to prepare in anticipation of treating you - including setting up your treatment room, reviewing your health history, and adding special touches to make your visit comfortable.

If you need to reschedule an appointment, we kindly request that you contact us by phone with advanced notice of two business days. We understand that conflicts arise; however, failing to attend your appointment or canceling without adequate notice may result in a minimum of $50 charge for the appointment. By notifying us early that you need to change your appointment will make it possible for us to offer your appointment time to another patient. We appreciation your cooperation and understanding.

Patient/Responsible Party Signature: _____ Date: _____

HANSON DENTAL

Release of Records

As an important part of your dental care, we would like to view any radiographic films that have been taken at another office in the last three to five years. Please complete the following records release form if you have been to another dental office during that time frame so that we may properly request information on your behalf.

Patient's Name: _____ Date of Birth: _____

Additional Family Members:

_____ _____
_____ _____
_____ _____

I authorize to release my dental records FROM:

Office Name: _____
City / State: _____/_____
Phone Number: _____
Email Address: _____
Or Fax: _____

Please send my dental records TO:

Office Name: _____
City / State: _____/_____
Phone Number: _____
Email Address: _____
Or Fax: _____

Reason for Release:

_____
_____

Patient/Responsible Party Signature: _____ Date: _____