WOODBINE FAMILY DENTISTRY

REID HINES, D.M.D.

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

First Name: Jr., II, Last Name: MI

Nickname / Alias: Birth Date (mm/dd/yy):

OFFICE PAYMENT POLICY

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Any unpaid balance over 90 days may be subject to a late fee.

Patient's Signature _____ Date _____

Parent or Guardian's Signature _____

RESPONSIBLE PARTY: IF PATIENT IS A MINOR

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Employer ☐ Other:

First Name: Jr., II, If employed, Company:

Last Name: MI

Nickname / Alias: Occupation:

Address: Address:

City: State: Zip:

Home Phone: City/State:

Work Phone: Ext Zip:

Cell Phone:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date (mm/dd/yy): Sex: ☐ Male ☐ Female

Social Security Number:

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic

APPOINTMENTS

WE ASK THAT WITH ANY CANCELLATION WE ARE NOTIFIED AT LEAST 24 HOURS IN ADVANCE. TWO (2) MISSED APPOINTMENTS WITHOUT THE 24 HOUR NOTICE, WILL RESULT IN A FEE OF $50, AND NO NEW APPOINTMENTS WILL BE MADE UNTIL THE FEE HAS BEEN PAID.

AN EMERGENCY FEE WILL BE ADDED TO AFTER HOURS VISITS.

DATE _____ SIGNATURE _____

PATIENT/PARENT OR GUARDIAN

WOODBINE FAMILY DENTISTRY

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SUBSCRIBER INFORMATION: THIS SECTION REFERS TO THE PATIENT IN WHOSE NAME THE INSURANCE IS FILED

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other:

First Name: Jr., II, If employed, Company:

Last Name: MI

Address: Insurance Co Name:

City: State: Zip:

Home Phone: Insurance Phone #:

Work Phone: Ext

Cell Phone: ID/Subscriber/Memb #

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date (mm/dd/yy): Sex: ☐ Male ☐ Female Group#

Social Security Number:

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic

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Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic

WOODBINE FAMILY DENTISTRY

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INSURANCE PAYMENT POLICY

I understand and agree that Dental and accidental policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Dental Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Dental Office will be credited to my account on receipt.

Patient's Signature _____ Date _____

Parent or Guardian's Signature _____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize the office of **WOODBINE FAMILY DENTISTRY** to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

Date _____ Signature of Patient and/or Guardian, if patient is Minor _____

WOODBINE FAMILY DENTISTRY

REID HINES, D.M.D.

PATIENT HEALTH RECORD

Date

Name (Last) (First) (Initial)

Spouse's Name

Address

City

State

Zip Code

Business Name

Home Phone

Business Phone

Cell Phone

E-mail Address

Date of Birth

Sex

Height

Weight

Occupation

Social Security No.

Single

Married

Emergency Contact

Phone#

Relationship to Patient

Whom may we thank for referring you to us?

MEDICAL HEALTH

Name and address of physician

Have you been under a physician's care during the past 2 years?

For

Have you been treated in a hospital in the past 2 years?

For

Have you ever had major surgery?

If female: Are you pregnant or nursing?

Have you ever had cankers or cold sores on your lips, tongue, gums, or body?

Do you use tobacco?

Have you had or do you now have:

WOODBINE FAMILY DENTISTRY

REID HINES, D.M.D.

PATIENT HEALTH RECORD - CONTINUED

Have you had or do you now have:	yes	no		yes	no
Abnormal blood pressure	☐	☐	Hepatitis	☐	☐
Low	☐	☐	HIV	☐	☐
High	☐	☐	Jaundice	☐	☐
Anemia	☐	☐	Kidney disease	☐	☐
Angina	☐	☐	Liver disease	☐	☐
Arthritis	☐	☐	Organ transplant	☐	☐
Artificial heart valves	☐	☐	Pacemaker	☐	☐
Artificial joints	☐	☐	Polio	☐	☐
Asthma	☐	☐	Prolonged bleeding	☐	☐
Cancer	☐	☐	Prolonged cough	☐	☐
Chemotherapy	☐	☐	Psychiatric treatment	☐	☐
Congenital heart lesions	☐	☐	Radiation therapy	☐	☐
Diabetes	☐	☐	Rheumatic fever	☐	☐
Drug dependency	☐	☐	Sickle cell anemia	☐	☐
Epilepsy	☐	☐	Stroke	☐	☐
Fainting	☐	☐	Thyroid disease	☐	☐
Glaucoma	☐	☐	Tuberculosis	☐	☐
Heart disease	☐	☐	Ulcers	☐	☐
Heart murmur	☐	☐	Venereal disease	☐	☐

ADDITIONAL INFORMATION

Have you had any disease, condition, or problem not previously listed?

Special needs (developmental) ☐ Yes ☐ No Explain:

PATIENT HEALTH RECORD - CONTINUED

Are you now taking or have you taken any prescription drugs during the past year?

Please list any medications you are currently taking:

Are you allergic to:

☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Latex ☐ Other

Please list anything you are allergic to:

AUTHORIZATION FOR TREATMENT

I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those anesthetics or medications which may be deemed advisable by the doctor. I will be responsible for any financial obligation for treatment on myself or the above named patient.

SIGNATURE _____ DATE _____

Woodbine Family Dentistry

Privacy Is Important to Us

Acknowledgment of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of **Woodbine Family Dentistry**. I hereby authorize, as indicated by my signature below, **Woodbine Family Dentistry** to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Patient Name

Patient or Guardian Signature _____ Date _____

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number:
- ☐ You may contact me on my mobile telephone number:
- ☐ You may contact me on my work telephone number:
- ☐ You may send me an email at:
- ☐ Other:

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from the list in the future.

1. Relationship: Date
   added/removed
2. Relationship: Date
   added/removed
3. Relationship: Date
   added/removed

****For Office Use Only**** We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited the acknowledgment
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (Please Specify)

Staff Person Initials: