WELCOME!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 Tell Us About Your Child

Today's Date: ____________

Child's Name: ____________

Nickname: ____________ ❑ Male ❑ Female

Child's Birthdate: ___/___/___ Child's Age: ____________

School: ____________ Grade: ____________

Child's Home #: (___)________ **SS #:** ____________

Child's Home Address: ____________ APT / CONDO #

____________ CITY ____________ STATE ____________ ZIP

2 Who Is Accompanying The Child Today?

Name: ____________

Relation: ____________

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we **Thank** for referring you: ____________

Other family members seen by us: ____________

____

Previous / Present Dentist: ____________

Last visit date: ____________

Parent's Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

3 ❑ Mother's Information ❑ Step Mother ❑ Guardian

Name: ____________ Birthdate: ___/___/___

Cell #: (___)________ Hm #: (___)________

Employer: ____________ Work #: (___)________

Email: ____________ SS #: ____________

❑ Father's Information ❑ Step Father ❑ Guardian

Name: ____________ Birthdate: ___/___/___

Cell #: (___)________ Hm #: (___)________

Employer: ____________ Work #: (___)________

Email: ____________ SS #: ____________

4 Person Responsible For Account

Name: ____________ **Relation:** ____________

Billing Address: ____________

____

Wk #: (___)________ **Ext:** ____ **Hm #:** (___)________

DL #: ____________ SS #: ____________

Who is responsible for making appointments?

Name: ____________

Wk #: (___)________ **Ext:** ____ **Hm #:** (___)________

5 Primary Dental Insurance

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (___)________

Group # (Plan, Local, or Policy #): ____________

Policy Owner's Name: ____________

Relationship to patient: ____________

Policy Owner's Birthdate: ___/___/___ ID #: ____________

Policy Owner's Employer: ____________

Orthodontic coverage? ❑ Yes ❑ No

Secondary Dental Insurance

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (___)________

Group # (Plan, Local, or Policy #): ____________

Policy Owner's Name: ____________

Relationship to patient: ____________

Policy Owner's Birthdate: ___/___/___ ID #: ____________

Policy Owner's Employer: ____________

Orthodontic coverage? ❑ Yes ❑ No

CONTINUED ON BACK

7 Why did you bring the child to the dentist today?

____
____

Has the child ever had a serious / difficult problem associated with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Child's Physician: ______________________

Phone #: ______________ Last Visit Date: __________

Is the child currently under the care of a physician? ❑ Yes ❑ No

Describe the child's current health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

____
____

Please list all drugs/materials that the child is allergic to: ___

____

6 Has the child ever had the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps / Disabilities
Y	N	Allergies to any drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Asthma	Y	N	Hepatitis
Y	N	Cancer	Y	N	HIV+ / AIDS
Y	N	Congenital Heart Defect	Y	N	Kidney / Liver Problems
Y	N	Convulsions / Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Diabetes	Y	N	Tuberculosis (TB)

Please discuss any medical problems that the child has had:

____
____
____

8 Does the child have the following habits?

Y	N	Lip Sucking / Biting
Y	N	Nail Biting
Y	N	Nursing Bottle Habits
Y	N	Thumb / Finger Sucking

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Initials: ______________ Date: __________

Doctor's Comments: ______________________

____
____
____
____
____

Medical History Update

1. Date: ________ Signature: ______________
Comments: ______________________
____

2. Date: ________ Signature: ______________
Comments: ______________________
____

3. Date: ________ Signature: ______________
Comments: ______________________
____

 www.informsonline.com © 2014 INFORMS 1-800-722-4884

Hamby Family Dental Center
Dr. Mike Hamby & Associates
7628 Purfoy Road
Fuquay-Varina, NC 27526

OFFICE POLICY

We would like to extend a warm welcome to you and your family. We strive to give the best, up-to-date dental care that can be provided. We would like to make you aware of our office policies:

1. Our office hours are as follow:	Monday	8 a.m. – 5 p.m.
	Tuesday, Wednesday, Thursday	8 a.m. – 5 p.m.
CLOSED FOR LUNCH	Friday	8 a.m. – 12 noon
DAILY 1 P.M. – 2 P.M.	Legal Holidays	Closed

2. We request that **all** medical forms be filled out **completely** and **honestly** to ensure our protection as well as your own.

3. Payment is expected at the time services are rendered either by cash, check, MasterCard, Visa, Discover, American Express or Care Credit. We accept credit or debit.

4. As a courtesy we file insurance for our patients. **We are in network with Aetna (any insurance participating in the Aetna network), Ameritas, BCBS of NC, Cigna discount plan, Delta Dental Premier, Guardian (DentalGuard network), UHC, The Principal, Reliance Standard and Standard Ins. Co.** Dental insurance is a contract between you and the insurance company. Co-Insurance is due at the time of service. You are responsible for any services denied by your insurance company. If insurance has not paid within 90 days of services rendered, then payment in full is expected from you. **We will file secondary insurance, but accept on assignment.**

5. Balances over 90 days, regardless of insurance coverage, will be charged a service charge of 1.5% monthly (18% annually) and/or may be turned over to collections and the credit bureau. Accounts turned over to a collection agency will be assessed a $25 placement fee.

6. Checks returned for Non-Sufficient Funds must be paid within 5 days plus $30 service fee.

7. There will be a **$50.00** charge for each broken appointment after the first broken appointment. **A broken appointment means that you were a no-show or canceled less than 24 hours prior to your appointment.** Multiple no-shows are subject to dismissal from the practice.

8. We are not currently accepting new Medicaid patients. Dental services for existing Medicaid patients will be discontinued if there are **any** broken appointments.

We welcome all comments and suggestions for improvement of our service to you. Please feel free to call the office during business hours. We are available to help with any problems you may encounter regarding appointments, billing, insurance, etc.

I have read and hereby agree to the above office policy.

______________________________ ________________

Patient/Guardian Signature Date

Phone (919) 552-2431 **Fax (919) 552-9743** **Email: Info@mikehambydds.com**

Mike P. Hamby, DDS, PA

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement*

PATIENT DISCLOSURE INTRUCTIONS

In general, the HIPPA privacy rule gives the individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

1. ___ Home telephone (__)___________________ Cell (__)______________________________________
   a. _____ OK to leave message with detailed information
   b. ______Leave message with call-back number only
   c. ______ Receive text messages
2. ____ Work telephone (_) ____
   a. ______ OK to leave message with detailed information
   b. _______Leave message with call-back number only
3. Written Communication
   a. ____ OK to mail my home address (**update address here**): ________________________________
   b. _____ OK to mail my work/office address ____
   c. ____ OK to fax to the number indicated (__)____
   d. _____ OK to email to ____
   e. _____ Other____

I allow you to give my clinical information to or answer questions from (check all that apply):

_____ Spouse _____ Parent _____ Step Parent ____ Child Name _________________
______ Other ______________________________________ ____ None

I have reviewed the Notice of Privacy Practices in the office and have been offered a copy of the same.

____
Patient Name

____ ____________________________
(Signature … Patient or Parent, if Minor) Date

For Office Use Only

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (Please specify) ____