Humphries Family Dentistry D.D.S.

Submit Print

Personal Information

Last name _____ First name _____ Middle name _____

Date of birth _____ Sex: ☐ Male ☐ Female | Relationship Status _____ SS# or Patient ID _____

Driver's license # _____ Email _____

Street Address _____ City _____ State _____ Zip code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation _____ Employer/School _____ Employer/School Phone _____

Referred By _____

Responsible party: (If you are completing this form for another person)

Your Name _____ Relationship to patient _____ Phone number _____

Emergency contact:

Name of contact _____ Relationship to patient _____ Phone number _____

Insurance Information

Do you have insurance? ☐ Yes ☐ No If no, how do you intend to pay for your visit? ☐ Cash ☐ Credit Card

Name of subscriber _____ Subscriber's SS# _____ Subscriber's date of birth _____

Ins. company name and address _____

Ins. company phone _____ Policy number _____

Is it through your employer? ☐ Yes ☐ No | Name of employer _____ Employer's phone _____

Name of spouse _____ Spouse date of birth _____ Spouse's SS# _____

Do you have secondary Insurance? ☐ Yes ☐ No **If yes**, please fill out the following:

Is it through your employer? ☐ Yes ☐ No | Name of employer _____ Employer's phone _____

Ins. company name and address _____

Ins. company phone _____ Policy number _____

Dental Experience

Reason for today's visit _____ Date of last dental care _____

What was done at that time? _____ Date if last dental x-rays _____

	yes	no
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐

	yes	no
If yes, how often? ☐ Daily ☐ Weekly ☐ Occasionally		
Are you currently experiencing dental pain or discomfort?	☐	☐
Do you have any earaches or neck pains?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Medical History

Are you now under the care of a physician? ☐ Yes ☐ No Physician's name _____ Phone number _____
Are you in good health? ☐ Yes ☐ No Has there been any change in your general health within the past year? ☐ Yes ☐ No
If yes, what condition was treated? _____ Date of last physical exam _____

	yes	no
Have you had a serious illnes, operation or been hospitalized in the past 5 years?	☐	☐
If yes, what was the problem?	☐	☐

_____

	yes	no
Are you taking or have you recently taken any prescription or over the counter medicine(s)?		
If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements:	☐	☐

_____

Misc. information

	yes	no
Do you wear contact lenses?	☐	☐
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
If yes, date _____ Any complications?	☐	☐
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
If yes, are you interested in stopping?	☐	☐
Do you drink alcoholic beverages?	☐	☐
If yes, how much did you drink in the last 24 hours? _____		
If yes, how much do you drink in a week? _____		

For women only

	yes	no
Are you on birth control pills or hormonal replacement?	☐	☐
Are you pregnant?	☐	☐
Number of weeks: _____ Nursing?	☐	☐

Allergy information

	yes	no
Are you allergic to or have you had a reaction to:		
If yes, please explain type of reaction in the space provided.		
Local anesthetics _____	☐	☐
Aspirin _____	☐	☐
Penicillin _____	☐	☐
Other antibiotics _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Sulfa drugs _____	☐	☐
Codeine or other narcotics _____	☐	☐
Metals _____	☐	☐
Latex (rubber) _____	☐	☐
Iodine _____	☐	☐
Animals _____	☐	☐
Other _____	☐	☐

Diseases or problems (Please let us know if you have struggled with any of the following.)

	yes	no
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐

Congenital heart disease (CHD)	yes	no
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in the last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

yes	no		yes	no		yes	no		yes	no	
☐	☐	Cardiovascular disease	☐	☐	Blood transfusion	☐	☐	Chronic pain	☐	☐	Neurological disorders
☐	☐	Angina			If yes, date _____	☐	☐	Diabetes Type I or II			If yes, specify _____
☐	☐	Arteriosclerosis	☐	☐	Hemophilia	☐	☐	Eating disorder	☐	☐	Mental health disorders
☐	☐	Congestive heart failure	☐	☐	DS or HIV infection	☐	☐	Malnutrition			If yes, specify _____
☐	☐	Damaged heart valves	☐	☐	Arthritis	☐	☐	Gastrointestinal disease	☐	☐	Recurrent Infections
☐	☐	Heart attack	☐	☐	Autoimmune disease	☐	☐	G.E. Reflux/persistent heartburn			If yes, specify _____
☐	☐	Heart murmur	☐	☐	Rheumatoid arthritis				☐	☐	Kidney problems
☐	☐	Low blood pressure	☐	☐	Systemic lupus erythematosus	☐	☐	Ulcers	☐	☐	Respiratory problems
☐	☐	High blood pressure	☐	☐	Asthma	☐	☐	Thyroid problems	☐	☐	Osteoporosis
☐	☐	Other congenital heart defects	☐	☐	Bronchitis	☐	☐	Stroke	☐	☐	Persistent swollen glands in neck
☐	☐	Mitral valve prolapse	☐	☐	Emphysema	☐	☐	Glaucoma			
☐	☐	Pacemaker	☐	☐	Sinus trouble	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Severe headaches/migraines
☐	☐	Rheumatic fever	☐	☐	Tuberculosis				☐	☐	Severe or rapid weight loss
☐	☐	Rheumatic heart disease	☐	☐	Cancer/Chemotherapy/ Radiation Treatment	☐	☐	Epilepsy	☐	☐	Sexually transmitted disease
☐	☐	Abnormal bleeding				☐	☐	Fainting spells or seizures	☐	☐	Excessive urination
☐	☐	Anemia	☐	☐	Chest pain upon exertion	☐	☐	Sleep disorder			

Do you have any disease, condition, or problem not listed above that we should know about? ☐ Yes ☐ No If yes, specify _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Today's date _____

Privacy Policy

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.

Uses and disclosures of health information

We use and disclose health information about you for your treatment, payment, and healthcare operations. For example: Treatment: We may use and disclose your health information to obtain payment for the 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 ualifications 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 disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any 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 and disclose your 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 our 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 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

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I certify that I, _____, have received and viewed the privacy policy.

Signature of Patient/Legal Guardian:_____ Today's date _____

Written Financial Policy

1) Payment in Full at the time of visit is due. We accept cash, money orders and all major credit cards.

2) For patients with dental insurance; we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Keep in mind however; your insurance benefit is **between you and your insurance company**. We therefore **cannot guarantee payment of your claims or accept responsibility of negotiating claims with insurance companies or other persons.**

3) If your insurance has not paid or denied your claim in 45 days, you are responsible for full payment of all unpaid claims.

YOUR PAYMENT IS TO BE PAID AT THE TIME OF EACH SERVICE. FEES ARE SUBJECT TO CHANGE EVERY YEAR.

No-Show and Cancellation Policy

Your visit has been reserved for you and the doctor; a 24 hour notice is required in advance for cancellations in order to allow all our patients to receive the best possible dental care. Without notice, there will be a charge for your broken appointment. I hereby authorize the release of any dental information necessary to process claims. I authorize the payment of benefits to the dentist described herein for services rendered.

Statement of Understanding

I certify that I, _____, have read and understand the written financial policy of Jim Humphries, D.D.S. Family Dentistry, and the informed consent.

Signature of Patient/Legal Guardian:_____ Today's date _____

Thanks for filling out your paperwork!

You have two options from here. First, you can submit this form to our practice and we'll have it ready when you arrive for your appointment. Or you can print it off yourself and bring it in with you to your appointment. See you soon!

Submit Print