HAMPTON FAMILY
DENTISTRY OF MIDDLETOWN
400 Midway Park Drive
Middletown, NY 10940
Phone: (845) 344-4336

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____
Email:_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone:____
_____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact Name: _____ Phone: _____Relationship to pt:_____

How did you hear about our practice?

☐Another patient, friend ☐Another patient, relative ☐ Dental Office ☐ Other_____

Name of person or office referring you to our practice: _____

Health History Information

Date of Last Dental Visit: _____ Where? : _____Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐AIDS
☐Allergies _____
☐High Cholesterol
☐Anemia
☐Arthritis
☐ Artificial Joints _____
☐Asthma
☐Blood Disease
☐Cancer
☐Diabetes
☐Dizziness
☐Epilepsy
☐Excessive Bleeding
☐Fainting
☐Glaucoma
☐Growths
☐Hay Fever
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Mental Disorders
☐Nervous Disorders
☐Pacemaker
☐Pregnancy
Due date:_____
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐ Thyroid Problems
☐Tuberculosis
☐Tumors
☐Ulcers
☐Venereal Disease
☐Codeine Allergy
☐Penicillin Allergy
OTHER:
☐_____
Other Conditions not listed
☐_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No Name of Physician: _____
  If yes, please explain: _____

Name of medication you are taking: _____
PRE-MED ☐ Yes ☐ No (If yes please list) _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

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Responsible Party Information

****The following is for: ☐ Myself ☐ Spouse/partner ☐ Parent/Guardian ****

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Cell Phone: _____

Address: _____
Street

_____
City State Zip Code

Medical Insurance Information

****The following is for: ☐ myself ☐ spouse/partner ☐ parent/guardian ****

Insured Name: _____Insurance Carrier: _____Policy #:_____

Insurance Address_____
Street City State Zip Code

Dental Insurance Information

Primary

Policy holder Name _____**DOB**_____**SS#**_____
Last First MI

Primary Insurance Company _____ _____ Group #/ID#:_____

Insurance Co. Address _____
Street City State Zip Code

Policy holders Employer _____

Address: _____
Street City State Zip Code

Patient's relationship to Insurance holder: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary

Policy holder Name _____DOB_____SS#_____
Last First MI

Secondary Insurance Company _____ _____ Group #/ID #:_____

Insurance Co. Address _____
Street City State Zip Code

Policy holders Employer _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Consent for Services (Please sign below)

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

x_____ **Date:** _____ **Relationship to Patient:** _____
Signature of patient, parent or guardian

x_____ **Date:** _____ **Relationship to Patient:** _____
Signature of guarantor of payment/responsible party.

HAMPTON FAMILY
DENTISTRY OF MIDDLETOWN

PATIENT HIPAA AWARENESS

With my permission, Hampton Family Dentistry may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Hampton Family Dentistry's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Hampton Family Dentistry reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Hampton Family Dentistry may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Hampton Family Dentistry may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Hampton Family Dentistry may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as Hampton Family Dentistry restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Hampton Family Dentistry to use and disclosure my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date

Turn page please →

HAMPTON FAMILY
DENTISTRY OF MIDDLETOWN

Welcome to your Hampton Family Dentistry appointment. We are delighted to welcome you to our practice and are please that you chose us to serve your dental needs.

Please read all of the information below carefully

ALL PATIENTS: Since appointed times are reserved exclusively for each patient, we ask that you please notify our office 24 hrs in advance of your scheduled appointment if you are unable to keep your appointment time (48 hrs if your appointment is 1 hour or more). Another patient, who needs our care, could be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your assistance in this regard. If not, unfortunately there will be a $50 fee for missed hygiene appointments and a $75 fee for missed doctor's appointment ($75 per hour appointment).

COPAYS: Are expected at the time of service. We gladly accept CASH, CREDIT CARD, CARE CREDIT, or CHECK. As a reminder, Nitrous is NOT a covered insurance expense. Our office fee for nitrous is $75 for children (Pediatrics) and $125 for children and adults (Specialist/ General/ Hygiene). Payment for this service is due before services is rendered.

REFERRALS: If you were referred to our office to see one of our Specialists for a consultation, YOU MUST make sure it is covered by your insurance in full. If it is not, the consultation fee to see the Oral Surgeon or Periodontist is $125. Please be prepared to pay for your visit in full by cash, credit card, or check, BEFORE services are rendered. If you are unable to do so, please reschedule your appointment.

PRIOR-AUTHORIZATIONS: If a prior authorization is needed for you dental procedures, we will do everything that we can do to assist, but be aware that this DOES NOT guarantees an approval. If a prior authorization is denied, it is in your best interest to work with your insurance company and advise us of how we can be of help.

RECORDS: It is our office policy that to receive a copy of your x-rays, you must fill out a release form. Please also be aware that our office has 14 days to have the information available to you. All paperwork must be picked up at our office as we DO NOT fax dental records (unless it is an urgent matter.)

IMPORTANT: If you are unsure whether a prior authorization is needed for work to be done, please contact your insurance provider or call us at (845) 344-4336. It is your responsibility to find out the requirements of your insurance company regarding any dental procedure that may be needed, ESPECIALLY your insurance yearly maximum and amount used to date, as it can cause additional financial responsibilities for you.

Patient Signature _____ Date _____