Honey Creek Dental
Patient Information

Your kindness in furnishing the following information will be used in strict confidence to prepare your clinical chart.

Name:

_____

(Last) (First) (Middle) (Preferred)

Address:

_____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____ Employer: _____

Date of Birth: _____ Sex: _____ SSN: _____

Marital Status (circle): Single Married Widowed Divorced Minor

***IF PATIENT IS A MINOR, LEGAL GUARDIAN'S NAME:**

_____

Spouse or Parent Information

Name: _____ Employer: _____

Date of Birth: _____ SSN: _____

Cell Phone: _____ Home Phone: _____

Account / Insurance Information

Person Responsible for account: _____ Relationship to Patient: _____

Dental Insurance Company: _____ Phone Number: _____

Insured Name: _____ Date of Birth: _____

SSN: _____ ID # on the Insurance Card: _____

Group Name/Policy Number: _____

General Information

Please tell us whom we may thank for referring you to us: _____

Has any member of your family been treated in our office? Yes No

Name of nearest relative or friend: _____ Phone #:_____

Name of Previous Dentist: _____ Date of last cleaning: _____

MEDICAL HEALTH INFORMATION

Name of Physician _____ Phone #: _____

GENERAL HEALTH (Please check): EXCELLENT ◯ GOOD ◯ FAIR ◯ POOR ◯

Are you taking any medication now? Yes No For what purpose? _____

PLEASE LIST ALL MEDICATIONS:

_____

_____

CHECK ALL THAT APPLY TO YOUR MEDICAL HISTORY (Past or Present)

- ○ *Anemia*
- ○ *Anxiety*
- ○ *Arthritis*
- ○ *Artificial Joints*
- ○ *Asthma*
- ○ *Blood Disease*
- ○ *Blood Thinner*
- ○ *Cancer*
- ○ *Diabetes*
- ○ *Dialysis*
- ○ *Dizziness/Fainting*
- ○ *Epilepsy/Seizures*
- ○ *Excessive Bleeding*
- ○ *Glaucoma*
- ○ *Head Injuries*
- ○ *Heart Condition*
- ○ *Heart Disease*
- ○ *Heart Murmur*
- ○ *Hepatitis*
- ○ *High Blood Pressure*
- ○ *High Cholesterol*
- ○ *HIV/AIDS*
- ○ *Jaundice*
- ○ *Kidney Disease*
- ○ *Kidney Transplant*
- ○ *Liver Disease*
- ○ *Mental Disorders*
- ○ *Mitral Valve Prolapse*
- ○ *Nervous Disorders*
- ○ *Pacemaker*
- ○ *Parkinson's*
- ○ *Radiation/Chemo*
- ○ *Respiratory Problems*
- ○ *Rheumatic Fever*
- ○ *Sinus Problems*
- ○ *Stomach Problems*
- ○ *Stroke*
- ○ *Thyroid condition*
- ○ *Ulcers*
- ○ *Venereal Disease*
- ○ *Other:* _____

_____

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE

Are you allergic to: Penicillin Codeine Local Anesthetics Sulfa Latex All Mycins?

Please list all other medications you are allergic to: _____

_____

Are you subject to prolong bleeding? Yes No Are you subject to fainting spells? Yes No

Are you pregnant? Yes No How many weeks? _____

Scheduling Appointments

Our office is by **appointment only facility –** expect in cases of extreme emergency. This policy helps our office stay on time with our appointments and keeps our waiting time to a **minimum.** It is our policy to see all scheduled patients at the time of their appointment. Please make sure you are on time for these appointments. When you are late you are into the next appointment time. This makes us late for the entire day. If we see that we cannot get you into the existing schedule due to your tardiness, we will reschedule your appointment.

Reminder Phone Calls

It is the policy of this office to place reminder phone calls ***if possible*** for upcoming appointments. ***It is still the patient's responsibility to be at the appointment on the correct date and time.***

No Shows and Cancellations

The policy of this office is to dismiss any patient who has a history (3 times) of NO SHOW or LATE CANCELLATION appointments. Please call to cancel your appointment at least 24 hours in advance. If you do not call to cancel your appointment, you are listed as a no-show appointment. If you call to cancel the day of your appointment, you are listed as a late cancellation.

No show and late cancellation appointments are charged $75 fee per ½ hour.

Dental Insurance and Payment Policies

We strive to furnish our patients with the best dental care available. If you are covered by dental insurance, it is important that **YOU** are aware of the extent of your coverage. As a courtesy to our patients, we will file your insurance for you but take no responsibility for what is not paid by them. Responsibility for full coverage of your dental service is yours. The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your policy is based on a schedule, it is your responsibility to obtain the schedule from your insurance company so you can pay your portion at the appointment. If this is not provided to us we will estimate your portion due. In order to file insurance we require specific information at a minimum of 24 hours prior to your scheduled appointment. This will allow us to obtain a general breakdown of your coverage. **AGAIN, WE URGE YOU TO BE FULLY INFORMED OF THE BENEFITS AVAILABLE TO YOU THROUGH YOUR INSURANCE COVERAGE.** Payment is expected at the time services are rendered. You may get an estimate treatment plan at the front desk to help you understand what you will need to pay at the time services are rendered. Co-payment and any percentage that you are responsible for MUST be paid at the time of appointment. **IF YOUR ACCOUNT BECOMES PAST DUE, PLEASE CALL US SO THAT A MUTUALLY AGREEABLE SOLUTION CAN BE FOUND.**

- **For all services that are not covered by dental insurance, we will expect full payment of the day that services are rendered.**
- **For all services that are covered by dental insurance, we will expect the patient to pay their portion of the fee on the day that services are rendered. Any variance in payment made by the insurance will be the responsibility of the patient.**
- **There is a $35.00 charge on all returned checks.**
- **For your convenience, Master Card, Visa, Care credit, cash and personal checks will be accepted.**

I have read and will abide by the office policies of Dr. Gilchrist and further will allow them permission to discuss my conditions with my physician and to request medical information. I agree to pay this account according to the policy of this office. I agree to pay a reasonable collections charge in the event of default.

_____ _____

Patient's Signature **Date**

_____

If Minor, Parent's Signature

HONEY CREEK DENTAL ASSOCIATES

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

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

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify) _____

Honey Creek Dental Authorization for use of Patient Photographic Images

Patient Name: _____

Patient's Date of Birth: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

The description of Photographic Images: (Circle YES to authorize or No to deny authorization)

Mouth & Teeth Only	**YES**	**NO**
Before & After pictures (may include face)	**YES**	**NO**
Advertising, Social media (Facebook, Instagram, & Website)	**YES**	**NO**

If you do NOT authorize any of these options, your photographic images will not be used to show other patients at any time. *Purpose(s) of this use or disclosure of Photographic images:* Our office does utilize photographic images for patient treatment, lab cases, insurance correspondence, and patient chart picture. This release is for sharing pictures outside of treatment between patient, doctor, lab and insurance. I authorize the following person(s) to make this use or disclosure: Honey Creek Dental. The following person(s) may be shown this patient information: Patients, labs, insurances and employees. (This form is focused on requesting authorization to show other patients primarily. We will disclose photos to labs, insurances and office staff in order to provide proper treatment and payment regardless of form authorization). I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Office. If I revoke this authorization, my revocation will **not** affect any actions taken by the dental practice before receiving my written revocation. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. The authorization expires 6 years from the date of this signed authorization.

Signature of Patient: _____ Date_____

If Personal Representative Please Print Name: _____

Relationship to Patient: _____ Signature: _____