Hammer and Van Zant Dental
Brian C Hammer, DMD and Assoc, PSC
2405 Ring Road, Elizabethtown, KY 42701, (270)737-8828

Patient Information

Patient Name: (First) _____ (Last)_____ (MI) _____ Date: _____

Birth Date: _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

Social Security #: _____ E-mail Address: _____

Address: (Street) _____ (Number) _____

(City) _____(State) _____ (Zip Code) _____

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

Employer Name: _____ Occupation: _____

MEDICAL HISTORY
- ☐ AIDS/HIV
- ☐ Acid Reflux/GI/Stomach
- ☐ Allergies (seasonal)
- ☐ Anemia/ Blood Disease
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness/ Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths/ Tumors
- ☐ Head Injuries
- ☐ Heart Artificial Valve
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur/ MVP
- ☐ Hepatitis/ Jaundice
- ☐ High Blood Pressure
- ☐ Immune Disorder
- ☐ Jaw Pain/TMD/TMJ
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Radiation/Chemothpy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease

DRUG ALLERGIES
- ☐ Codiene Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Other

_____

WOMEN - *Are you:*
- ☐ Pregnant/Due Date_____
- ☐ Nursing
- ☐ Taking Birth Control

DENTAL HISTORY
- ☐ Bad Breath
- ☐ Bite/ Chew Nails
- ☐ Biteguard Therapy
- ☐ Bleaching Treatment
- ☐ Bleeding Gums
- ☐ Blisters/ Sores on Lips
- ☐ Broken Fillings/ Teeth
- ☐ Cheek Biting/ Chewing
- ☐ Clench/Grinding Teeth
- ☐ Gums Swollen/Tender
- ☐ Jaw Pain or Tiredness
- ☐ Loose Teeth
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Pain Around Ear
- ☐ Periodontal Treatment
- ☐ Smoking/ Tobacco
- ☐ Tooth Sensitivity
- ☐ Wisdom Teeth Removed

☐ ***Do you snore?***

Last Dental Visit Date:
_____

Last Dental X-rays:
_____

Do you take antibiotics (premed) for dental appts? _____ If so, what antibiotic? _____

Are you taking Coumadin, Plavix or other blood thinners? _____ If so, what? _____

Have you taken medicine for osteoporosis (e.g. Fosomax)? _____ If so, what? _____

Please list ALL Medications that you are now taking (continue on back or attach list if needed):

_____ _____ _____ _____

Name and phone number of your general practitioner/ medical doctor: _____

Any Health Problems Not Already Listed (Please Explain): _____

Who may we thank for referring you to our office? ☐ Another patient _____
☐ Dental Office _____ ☐ Insurance _____ ☐ Internet ☐ Phone Book ☐ Other _____

Dental Insurance Information

Primary Insurance:

Insurance Plan Name:_____ **Ins. Co. Phone #:**_____

Name of Policy Holder:_____

Policy Holder's Birth Date:_____ **ID #:** _____ **Group #:** _____

Policy Holder's Employer Name:_____

Patient's relationship to policy holder: ☐ **Self** ☐ **Spouse** ☐ **Father** ☐ **Mother** ☐ **Guardian**

Secondary Insurance:

Insurance Plan Name and Address:_____

_____

Name of Policy Holder:_____

Holder's Birth Date:_____ **ID #:** _____ **Group #:** _____

Consent For Services

I have read and understand the above information. To the best of my knowledge, I have accurately answered the above questions. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to determine appropriate and healthful dental treatment. 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 also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to third party payers and/ or other health practitioners.

Signed:_____ ***Date*:**_____ ***Relationship to Patient:***_____

EMERGENCY CONTACT:

Name:_____ **Phone #:** _____ **Relationship:** _____

Hammer and Van Zant Dental Cancellation Policy:

If you need to cancel your appointment with us, we require at least 24 hours notice. This gives us the opportunity to provide care to another patient who can use the appointment time. If 24 hours notice is not given for *two* appointments, we reserve the right to not schedule you for any more appointments, and to discharge you as a patient.

I have read and understand the cancellation policy.

SIGNED: _____ ***DATE:*** _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPPA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability And Accountability Act of 1996. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); Obtaining payment from third party payers (e.g. my insurance company); The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

HAMMER AND VAN ZANT DENTAL
Financial Policy

Payment is expected at the time service is rendered.
Methods of payment include:

- Cash/ check, Visa, Master Card, Discover, Care Credit

If you have dental insurance, we will be happy to file your claims with your primary carrier. You will be expected to pay your deductible and percentage the day treatment is provided. We will file and allow up to 60 days for an insurance response before contacting you. If your claim is denied and/or payment is delayed, *you will be expected to pay the claim amount.*

IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS OF YOUR POLICY, INCLUDING ITS LIMITATIONS AT THE TIME OF TREATMENT.
We will help you as much as we are able; however, it is impossible for us to know all of the details and limitations of every insurance policy. IF an insurance company denies payment, the unpaid portion becomes the patient's responsibility. We are not responsible for anything an insurance company denies payment for.

If your account is unpaid and goes to a collection agency, we will no longer be able to see your family due to the deteriorating patient/ doctor rapport.

Parents, guardians, and/or personal representatives are responsible for all fees and services rendered for treatment of a minor/child on the day of service.

☐ I have read and understand and acknowledge my HIPAA rights. (The section at the top of this page).

☐ I have read and understand the financial policy. (The section just above this section on this page).

Print Name:_____ Sign:_____ Date:_____