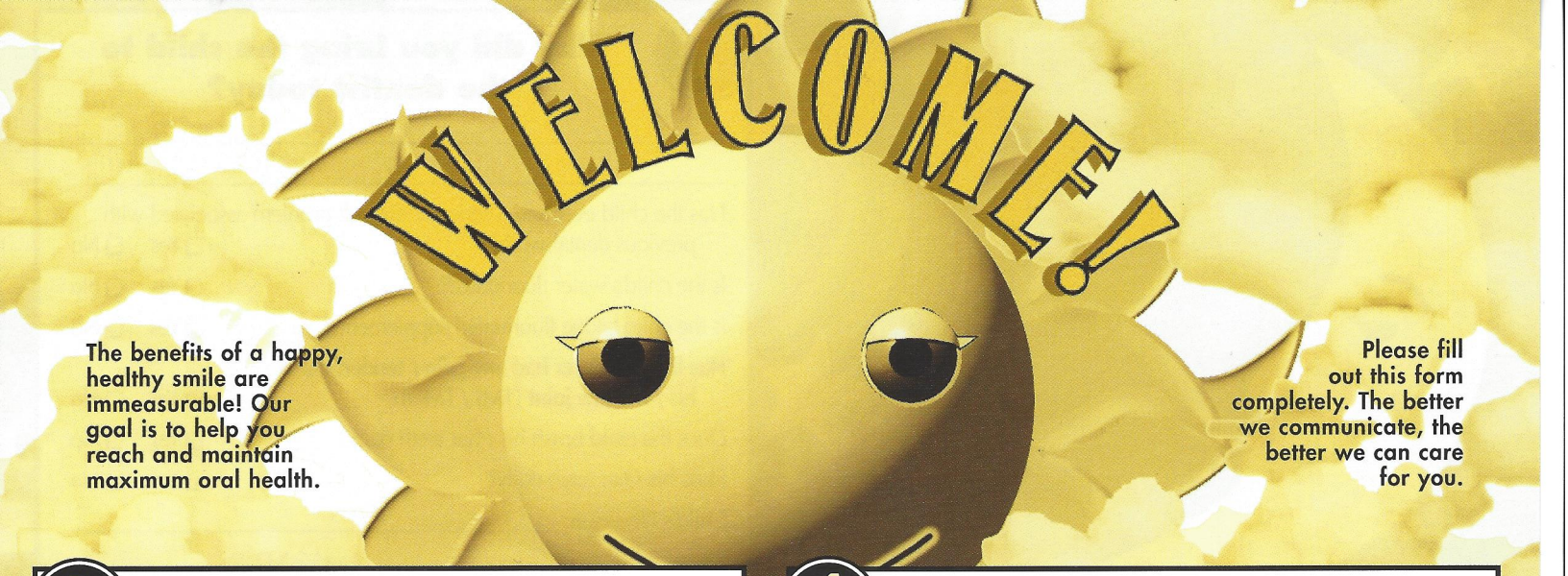

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

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: _____

_____

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 follows:

	Monday	8am - 6pm
	Tuesday, Wednesday, Thursday	8am - 5pm
CLOSED FOR LUNCH	Friday	8am - 12 noon
DAILY 1PM - 2PM	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 Ameritas, BCBS of NC, Cigna (discount plan), Delta Dental, 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 **$35** 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 service for existing Medicaid patients will be discontinued if there **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) _____