Welcome

Young Adult

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational.
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOU: Today's Date: _____

Name: _____
Last First Mi

Nickname: _____ ❑ Male ❑ Female
Birthdate: ____/____/____ Age: _____
School: _____ Grade: _____
College: _____ SS #: _____
E-mail Address: _____
Hobbies / Sports: _____

_____
Home Phone: (_____) _____
Home Address: _____

_____
City State Zip

Whom may we Thank for referring you? _____

_____
Previous / Present Dentist: _____
(Please Circle)

Last visit date: _____

Other family members seen by us with Birthdate:

Name	Birthdate
_____	____/____/____
_____	____/____/____
_____	____/____/____

Who is responsible for making appointments?

Name: _____ Relation: _____
Work Phone: (_____) _____
Home Phone: (_____) _____

Parent Information:

Who is accompanying you today? _____
Name: _____ Relation: _____
Does this person have legal custody of you? ❑Yes ❑ No
Parent's Marital Status: (Please Circle)
Single Widowed Married Divorced Separated Partnered

Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ____/____/____
Email Address: _____
Wk Phone:(____)_____ Hm Phone:(____) _____
Cell Phone:(____)_____ SS #: _____
Employer: _____

Father's Information: ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ____/____/____
Email Address: _____
Wk Phone:(____)_____ Hm Phone:(____)_____
Cell Phone:(____)_____ SS #: _____
Employer: _____

Person Responsible For Account:

Name: _____ Relation: _____
Employer: _____ DL #: _____
Wk #:(____)_____ Cell #:(____)_____
Billing Address: _____

_____
City State Zip

Previous Address: _____

_____
City State Zip

Primary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Name: _____
Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____
Group # (Plan, Local or Policy #): _____
Policy Owner's Name: _____
Relationship to Policy Owner: _____
Policy Owner's Birthdate: ___/___/___ SS #: _____
Policy Owner's Employer: _____
Employer's Address: _____

_____
City State Zip

Secondary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Name: _____
Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____
Group # (Plan, Local or Policy #): _____
Policy Owner's Name: _____
Relationship to Policy Owner: _____
Policy Owner's Birthdate: ___/___/___SS #: _____
Policy Owner's Employer: _____
Employer's Address: _____

_____
City State Zip

CONTINUED ON BACK

Why have you come to the dentist today? _____

_____

Have you experienced problems with previous dental work? ❑ Yes ❑ No

Is your water fluoridated? ❑ Yes ❑ No

Are you taking fluoridated supplements? ❑ Yes ❑ No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Do you brush your teeth daily? ❑ Yes ❑ No

Floss your teeth daily? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

Do you require antibiotics before dental work? ❑ Yes ❑ No

Have you ever taken Phen-Fen? ❑ Yes ❑ No
Also known as Redux or Pondimin. If so, when? _____

Are you currently under a physician's care? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Please describe your current physical health:
❑ Good ❑ Fair ❑ Poor

Please list all drugs that you are currently taking: _____

_____

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No ❑ Unsure Week #: ___

Are you nursing? ❑ Yes ❑ No

For orthodontic treatment please complete the following:

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Have you ever been evaluated/had orthodontic treatment before? ❑ Yes ❑ No

Have there been any injuries to your face, mouth, teeth or chin? ❑ Yes ❑ No

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Have you been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Do you still have your wisdom teeth? ❑ Yes ❑ No

Have you played any musical instruments? ❑ Yes ❑ No

If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Aspirin
Y N Any Metal / Jewelry
Y N Plastic
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other Allergies that you have _____

_____

DID/DO YOU EXPERIENCE ANY OF THE FOLLOWING?

Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb / Finger Sucking
Y N Tongue Thrust
Y N Clenching / Grinding Teeth
Y N Lip Sucking / Biting
Y N Mouth Breather
Y N Nail Biting
Y N Were you breastfed?
Y N Used Pacifier

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Abnormal Bleeding
Y N Anemia
Y N Any Hospital Stays
Y N Artificial Bones / Joints
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Hives
Y N HIV+ / AIDS
Y N Kidney Problems
Y N Liver Problems
Y N Lupus
Y N Measles
Y N Mononucleosis
Y N Mitral Valve Prolapse
Y N Rheumatic / Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are your Immunizations current? ❑ Yes ❑ No

Please discuss any serious medical problems you've experienced:

_____

_____

Is there anything you would like to discuss with the doctor in private? ❑ Yes ❑ No

I understand that I am responsible (If 18 yrs or older) for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's insurance does not cover.

_____
Patient Signature Date

_____
Parent/Guardian Signature (If Necessary) Date

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.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____
Signature of Patient and/or Parent/Guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
Signature of Patient and/or Parent/Guardian Date

The Patient or Parent/Guardian 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

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: ___/___/___

Doctor's 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) _____