Tell Us About Yourself

Hammerbeck Dental
759 S. St. Augustine St.
Pulaski, WI 54162
(920) 822-8388

PATIENT INFORMATION

Legal Name _____ Preferred Name_____ □ Male □ Female

□ Married □ Single □ Child □Other Birth Date ____/____/_____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Cell _____ Work _____

Email _____ Employer_____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

□ CHECK IF SAME AS ABOVE.

Name _____ Birth Date ___/___/_____ Social Security #_____

Relation _____ Phone _____ Employer _____

Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE INFORMATION

Please provide a copy of your dental insurance card.

Primary Dental Insurance

Carrier _____ Phone _____ Group Name/Employer _____

Group # _____ ID #_____ Insured's Name _____

Insured's Birth Date ___/____/_____ Insured's Social Security #_____ Relation _____

Secondary Dental Insurance

Carrier _____ Phone _____ Group Name/Employer _____

Group # _____ ID #_____ Insured's Name _____

Insured's Birth Date ___/____/_____ Insured's Social Security #_____ Relation _____

TO ENSURE YOU GET THE BEST COVERAGE, PLEASE ALSO PROVIDE A COPY OF YOUR MEDICAL INSURANCE CARD.

MEDICAL AND DENTAL HISTORY

HAMMERBECK DENTAL

Patient Name _____**SSN**_____ **Birth Date** _____/_____/_____

Address_____**City**_____**State**_____ **Zip**_____**Phone**_____

Email_____**Insurance Carrier**_____**Employer**_____

Subscriber_____**Group#**_____**ID#**_____**Relation to Insured**_____

Physician _____ City _____ State_____ Phone _____
Pharmacy_____City_____State_____Phone_____

ALLERGIES (check all that apply)

□ Codeine
□ Ibuprofen
□ Iodine
□ Latex
□ Local Anesthetic
□ Penicillin
□ Sulfa
□ NSAIDs
□ Other _____
□ NONE

List all medications you are currently taking:

_____
_____
_____
_____

Have you ever been told you require premedication before dental treatment? □Yes □No Reason _____

Place a checkmark to indicate if you have or have had any of the following:

□ Abnormal Bleeding
□ Abnormal Blood Pressure
□ AIDS/HIV
□ Seasonal Allergies
□ Anemia
□ Arthritis
□ Artificial Heart Valves
□ Artificial Joints
□ Back Problems
□ Blood Disease
□ Blood Thinners
□ Cancer, Specify Type: _____
□ Chemical Dependency
□ Chemotherapy/Radiation
□ Cortisone Treatments
□ Cough, persistent or bloody
□ Diabetes
□ Eating Disorder
□ Emphysema
□ Epilepsy
□ Fainting or Dizziness
□ Glaucoma
□ Headaches
□ Head/Neck/Oral Cancer
□ Heart Murmur
□ Heart Problems, Describe: _____
□ Hepatitis, Type _____
□ Herpes/Cold Sores
□ HPV
□ HPV Vaccine Received, Date:_____
□ Jaundice
□ Jaw Pain
□ Kidney Disease
□ Liver Disease
□ Memory Loss
□ Mitral Valve Prolapse
□ Pacemaker
□ Psychiatric Care
□ Rapid Weight Gain/Loss
□ Respiratory Disease
□ Rheumatic Fever
□ Shortness of Breath
□ Sinus Problems
□ Stroke
□ Swelling of Extremities
□ Thyroid Condition
□ Tuberculosis
□ Ulcer
□ Other: _____
_____
_____
_____

Women Only:
□ Pregnant or Nursing

Emergency Contact: _____ Phone_____ Relation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Signature of Reviewing Doctor Date

Hammerbeck Dental

759 S. St. Augustine St.
Pulaski, WI 54162
(920) 822-8388

Patient _____ Date of Birth _____

This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the adults named below to escort my child for dental treatments. I agree to provide payment information so the above mentioned office may obtain payment on the day of service, unless prior arrangements have been discussed.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If child is over 13, please check one:

□ Since my child is over the age of 13, I also give permission for him/her to present for cleanings, exams, x-rays, fluoride and treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or root canal therapies, will be performed unless I am notified by telephone.

□ Although my child is over 13, I wish for myself or one of the above mentioned adults to be present for all dental appointments.

_____ _____
Print Name of Person Completing Form Relationship to Patient

_____ _____
Signature of Person Completing Form Date

Hammerbeck Dental
759 S. St. Augustine St.
Pulaski, WI 54162

Acknowledgement of Privacy Notice

Patient Name _____ Date of Birth _____

Name/Relationship of Person Completing Form, if not Patient _____

1. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment records), via electronic transmission, including emails without special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below-named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

Name of Authorized Person: _____Relationship _____

2. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the Notice and one will be provided to me.

Signature of Patient/Legal Guardian: _____ Date: _____

For Office Use Only

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

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ an emergency situation prevented us from obtaining the acknowledgment

___ Other:_____

Employee Signature: _____ Date: _____

Hammerbeck Dental

759 S. St. Augustine St.
Pulaski, WI 54162
(920) 822-8388

Patient Name _____ Date of Birth _____

FINANCIAL AGREEMENT: Unless a prior payment arrangement has been approved, payment is due on the day of service. If you have financial concerns, please discuss payment arrangements with our office. All balances are due within 15 days from the date charges incurred. There will be a charge of 10% APR or $5.00 per month, or whichever is greater, on all accounts over 30 days. All accounts over 90 days will be sent to a collection agency or an attorney for further action, which may result in legal action and have a negative effect on your credit score. You are responsible for any fees associated with payments on your account, which includes: a $35.00 fee for each returned check and each fee incurred for any credit card chargebacks.

DENTAL INSURANCE: As a courtesy, we will file your claims; you must provide and update your insurance information. Your insurance policy is a contract between you and the insurance company; we are not a party to that contract. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. All charges not paid by your insurance company are your responsibility. Fees for noncovered services, along with deductibles, coinsurances and co-payments are due at the time of treatment.

MINOR PATIENTS: The legal guardian of the minor is responsible for full payment on the day of service. In the case of divorced or separated parents, the legal guardian accompanying the child is responsible for payment and will collect any portions due from secondary parties.

BROKEN APPOINTMENTS: Our practice requires 48 weekday hours notice to reschedule. If adequate notice is not given, we reserve the right to charge a rescheduling fee at our discretion.

RECORDS AND RADIOGRAPHS: Original records, including radiographs, are the property of the above mentioned office. You may request a copy of your records and x-rays in writing. A duplication fee may be charged; if applicable, you will be informed of this prior to records being released.

I have read and fully understand all policies listed above. I understand that in the event my account becomes delinquent, I will be responsible for any collections, legal fees, and any other charges incurred to collect this account. Additionally, by signing this form I authorize Hammerbeck Dental to process credit card transactions initiated by me via mail, online, or phone and I authorize my credit institution to pay.

I authorize for the above mentioned person to receive dental treatment deemed necessary by the providers at Hammerbeck Dental. I understand that the use of local anesthetics carries a risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. I consent to the release of my information, advice and treatment to another doctor should my dental needs require doing so.

I hereby authorize and release information and payment of my dental benefits directly to the above named office. I further authorize to the use and disclosure of my information to carry out payment activities in connection with insurance claims.

This consent shall be considered in effect until rescinded or revoked.

_____ _____
Printed Name of Person Completing Form Relation to Patient

_____ _____
Signature of Person Completing Form Date