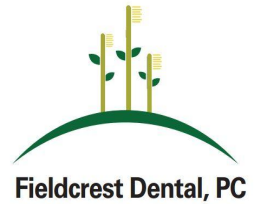


Adult Patient Health History



How did you hear about us? _____

Name or source

Date: _____

Patient Name: _____
Last First Middle

Mailing Address: _____
House number & PO Box if applicable City State Zip Code

Email address: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: _____ Social Security Number: _____

Male/Female (circle one) Single, Married, Separated, Divorced or Widowed (circle one)

Your Employer: _____ Position: _____
Business name City & State

Do you have Dental Insurance through your employer? Yes or No

Name of Insurance Company: _____

Policy/Group number: _____ Member ID number: _____

Address: _____ Phone Number: _____
(found on the back of your insurance card) (found on the back of your insurance card)

Spouse Information

Spouse's Name: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____

Employer: _____ Position: _____
Business name City & State

Does your spouse have Dental Insurance through their employer? Yes or No

If yes, are you covered under their dental insurance? Yes or No

If yes, Name of Dental Insurance Company: _____

Policy/Group number: _____ Member ID number: _____

Who is responsible for this account: _____

Emergency contact Person: _____

Name

Relationship

Phone#

List All Medications You Are Currently Taking or Should be:

List All Previous Surgeries with Dates:

Have you ever taken medications for Osteoporosis?

Yes / No

Do you use tobacco products?

Yes / No

History of Drug/Alcohol Addiction?

Yes / No

Is your General Health Good? Yes / No (if no, why) _____

Currently under Doctors Care? Yes / No (if so, why) _____

Physician's Name _____ Phone # _____

Women ONLY: **Pregnant/Trying To Get Pregnant?** Yes / No

Nursing? Yes / No

Taking Oral Contraceptives? Yes / No

Are you allergic to any of the following?

Penicillin Yes / No Codeine Yes / No Acrylic Yes / No Metal Yes / No Latex Yes / No

Sulfa Drugs Yes / No Other(s): _____

Please list any dental/oral concerns _____

Please circle any of the following conditions that you have currently or have had in the past:

Cardiovascular

Angina/Chest Pain
Congenital Heart Problems
Heart Attack / Failure
High / Low Blood Pressure
Heart Surgery / Artificial Valve
High Cholesterol
Infective Endocarditis
Irregular Rhythm / Pacemaker

Murmur

Rheumatic Fever

Blood

Anemia
Hemophilia
HIV / AIDS
Bruise Easily / Thin Blood
Organ Transplant (Received or Donor)

Respiratory

Asthma
COPD
Easily Winded
Emphysema
Frequent Sinus Trouble
Other Breathing Problems
Tuberculosis

Neural / Neurovascular / Psych

Alzheimer's / Dementia
Anxiety / Depression
Epilepsy / Seizures
Fainting / Dizzy Spells
Glaucoma
Neuralgia
Psychiatric Care (Other) _____
Stroke

Liver/Kidney/Gastro-Intestinal

GERD (Acid Reflux)
Hepatitis
Kidney Problems
Liver Disease (Other)
Ulcers

Musculoskeletal

Arthritis / Gout
Artificial Joint
Bone / Muscle Other _____
Osteoporosis

Cancer

Cancer (Type)
Chemotherapy
Radiation Therapy

Immune System Diabetic Type 1 or 2

Please be sure to read, sign and date of all the bottom approvals.

Patient, Parent or Guardian:

This information has been answered to the best of my knowledge, and I will update Dr Hamper, DMD and their staff of any medical changes in the future. My signature authorizes the release of information to my insurance company and it authorizes assignment of benefits when applicable.

Signature: _____ **Date:** _____

Patient, Parent or Guardian:

I hereby agree to the following terms and conditions:

There is a 5% annually late charge assessed on all balances after 90 days past due. Checks, which are declared non-sufficient funds, will be charged a \$25.00 service fee. Also, the undersigned agrees to pay collections fee of 30% of the total owed when sent to collections. All attorney fees and court costs incurred by the creditor. All the information provided is correct.

I have read and understand the above paragraph in its entirety.

Signature: _____ **Date:** _____

Patient, Parent or Guardian:

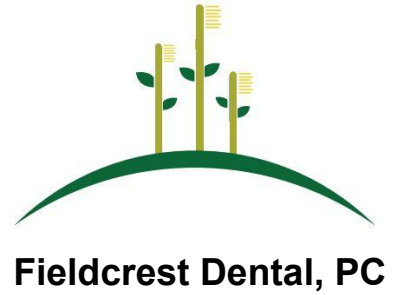
NOTICE OF PRIVACY PRACTICE

I have received a Notice of Privacy Practice

Patient name (print) _____

Signature: _____ **Date:** _____

Patient unable or refused to sign acknowledgement



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT: Name (Please Print)

List individuals who you would like involved in your dental care. By writing their names on this form, you consent to the release of your dental information to them. For example, if you want us to be able to discuss dental information, including your treatment and/or financial information, with your husband/wife, you must list their names below. This includes discussing fillings, crowns, insurance payments with them.

Name: _____

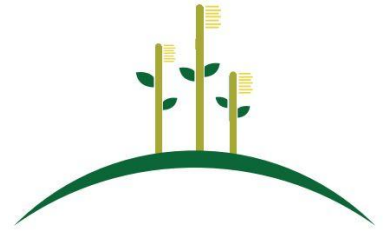
Relationship: _____

Name: _____

Relationship: _____

Signature: _____

Date: _____



Fieldcrest Dental, PC

Appointment Cancellation Guidelines

We strive to provide excellent dental care to you as well as to the rest of our patients. In an attempt to be consistent with this, we have appointment cancellation guidelines so that we can meet the needs of all of our patients. When an appointment is scheduled, that time has been set aside especially for you. When it is missed, that time cannot usually be used to treat another patient.

Our policy is as follows:

We require **48 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a failed appointment. We care about you and hope it never comes to this, but we allow **2 failed appointments** in any 2 year period before we ask that you establish yourself at another dental office. We do this because the number of patients that cannot be seen due to failed appointments is too great.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. This guide is our north star, but we also reserve the right to alter these guidelines as needed in extenuating circumstances.

We thank you for your trust in us and value our continued relationship.

I, _____, **have read and understand the above notice.**
Print Name