Michael A. Hunting, D.D.S.

Quality care from a dentist who treats you like family

Welcome!

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely.
If you have questions, please ask us - we will be happy to help.

Patient Information *(Confidential)*

Cell Phone _____

*Name*_____ *Birthdate*___/___/___ *Home Phone*_____

*Address*_____ *City*_____ *State*_____ *Zip*_____

*Check One: Minor*__ *Single*__ *Married*__ *Divorced*__ *Widowed*__ *Separated*__ *Soc. Sec #*_____

*If full-time Student, Name of School / College*_____ *City*_____ *State*_____

*Patient's Employer (if Applicable)*_____ *Work Phone*_____

*Business Address*_____ *City*_____ *State*_____ *Zip*_____

*Name of Spouse (if Applicable)*_____ *Employer*_____ *Work Phone*_____

*Whom May We Thank for Referring You?*_____

*Person to Contact in Case of Emergency*_____*Phone*_____

Responsible Party

*Name of Person Responsible for Payment on this Account*_____ *Relation to Patient*_____

*Address*_____ *City*_____ *State*_____ *Zip*_____

*Home Phone*_____ *Birthdate* ___/___/___ *Soc. Sec #*_____ *Driver's License #*_____

*Employer*_____ *Work Phone*_____

*Is this Person Currently a Patient in our Office? Yes*___ *No*___

Primary Insurance Information

*Name of Insured*_____ *Relation to Patient*_____

*Birthdate*___/___/___ *Soc. Sec #*_____ *Date Employed*_____

*Employer*_____ *Union or Local#*_____ *Work Phone*_____

*Address of Employer*_____ *City*_____ *State*_____ *Zip*_____

*Insurance Company*_____ *Group # or Policy I.D. #*_____

Secondary Insurance Coverage *(Complete if You Have Additional Insurance)*

*Name of Insured*_____ *Relation to Patient*_____

*Birthdate*___/___/___ *Soc. Sec #*_____ *Date Employed*_____

*Employer*_____ *Union or Local#*_____ *Work Phone*_____

*Address of Employer*_____ *City*_____ *State*_____ *Zip*_____

*Insurance Company*_____ *Group # or Policy I.D. #*_____

Patient Medical History

*Primary Care Physician*_____ *Office Phone*_____ *Last Exam*_____

	Yes	No
1. Are you presently receiving medical treatment?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness in the past 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medications?	☐	☐
If yes, please list medications you currently take.		
4. Do you use tobacco?	☐	☐
5. Do you use any controlled substance?	☐	☐

6. Are you allergic to or have you had a reaction to any of the following?	Yes	No
Local Anesthetics	☐	☐
Penicillin or other Antibiotic	☐	☐
Codeine / Other Pain Medication	☐	☐
Sedatives	☐	☐
Any Metals	☐	☐
Latex Rubber	☐	☐
Other (please list)_____	☐	☐
7. Women Only:		
Are you pregnant?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Stroke	☐	☐	Leukemia	☐	☐
Low Blood Pressure	☐	☐	Rheumatic Fever	☐	☐	Arthritis	☐	☐
Heart Attack	☐	☐	Respiratory Problems	☐	☐	Sexually Trans. Disease	☐	☐
Heart Disease	☐	☐	Hay Fever / Allergies	☐	☐	AIDS or HIV Infection	☐	☐
Angina	☐	☐	Tuberculosis	☐	☐	Liver Disease	☐	☐
Cardiac Pacemaker	☐	☐	Asthma	☐	☐	Hepatitis / Jaundice	☐	☐
Heart Murmur	☐	☐	Fainting / Seizures	☐	☐	Kidney Disease	☐	☐
Mitral Valve Prolapse	☐	☐	Epilepsy / Convulsions	☐	☐	Diabetes	☐	☐
Hemophilia	☐	☐	Cancer	☐	☐	Artificial Joint or Implant	☐	☐
Anemia	☐	☐	Radiation Therapy	☐	☐	Other_____		

Patient Dental History

*Name and Location of Previous Dentist*_____ *Date of Last Exam*_____

	Yes	No
1. Do your gums bleed when brushing or flossing?	☐	☐
2. Are any of your teeth sensitive to hot or cold?	☐	☐
3. Are any of your teeth sensitive to pressure?	☐	☐
4. Have you had any head, neck or jaw injuries?	☐	☐
5. Have you had orthodontic treatment?	☐	☐
6. Do you clench or grind your teeth?	☐	☐
7. Have you had difficulty with any previous dental treatment?	☐	☐
8. Have you had prolonged bleeding after extractions or other dental procedures?	☐	☐

*9. What is the reason for today's visit?*_____

*10. How would you describe your current dental condition?*_____

*11. How would you like to see your condition corrected?*_____

12. If you could change anything about the appearance of your teeth, what would it be? _____

Consent for Treatment and Authorization for Release of Information

I authorize and give consent for performance of dental services as agreed between Dr. Hunting and patient and/or parent or guardian to be necessary or advisable. This includes the use of local anesthetic or other medications as indicated. I certify that I have read and understand the above information and that the above questions have been accurately answered to the best of my knowledge. I authorize Dr. Hunting to release any information including the diagnosis and the records of any treatment or examination to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to Dr. Hunting insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

X_____

Signature of Patient (or Parent / Guardian if Minor)

OUR OFFICE FINANCIAL POLICY AND YOUR DENTAL INSURANCE

OUR "NO SURPRISES" POLICY:

You will be consulted before any treatment is undertaken.
The investment necessary to complete your treatment is based on an estimate derived from our examination. Should additional unforeseen problems arise as treatment progresses, this estimate may be revised.

PATIENTS WITH NO DENTAL INSURANCE:

Cash patients are expected to pay in cash, check, or credit card **the day the service is rendered** unless specific arrangements are made in advance.

PATIENTS WITH DENTAL INSURANCE COVERAGE:

You may direct your insurance company to pay their share of cost directly to this office (this is called Assignment of benefits). As a courtesy to our patients, this office accepts insurance assignments; (we will give you credit for this anticipated amount). Acceptance of insurance assignments by this office does not absolve the patient of **full responsibility** of charges for treatment rendered.

Your insurance company will be billed for services as they are rendered. Because of the extreme delay in receiving payment from the insurance company, **we do ask that you pay your estimated portion of the charges when the service is rendered.** The estimate provided for the patient is to be considered a **guideline** until the final insurance payment is received and the patient's account has been reconciled. Our office can make no guarantee of the insurance payment as estimated; however we are always happy to be of assistance in helping you maximize your dental insurance benefits.

MISSED APPOINTMENTS:

No charge will be made for rescheduling an appointment provided at least 24 hours notice is given, otherwise a minimum charge of $25 **per half hour missed** will be made.

Please remember that once an appointment has been made, that this time has been reserved **specifically** for you. _____ Initial here.

This office is HIPPA compliant. If you would like a copy, please see the office manager.
_____ Initial here.

We are here to help… please feel free to call if you have any questions.

Signature of Responsible Party _____

Date _____