# Hunt Family Dental Care

Adam C. Hunt, DMD

## Welcome to the Practice

**Please let us know whom we can thank for referring you to our office:** _____

Every patient is special and unique. It is our goal to help you experience the wonderful benefits of good dental health. Our mission is to create a warm, friendly and professional environment that provides the highest level of dental care possible. We pride ourselves on the service we provide to our patients. Our staff is looking forward to working with you to create a beautiful healthy smile to last a lifetime.

It is important for you to know what to expect at your new patient visit.
***Children** (under 18) will receive a comprehensive examination, x-rays, cleaning and fluoride treatment (if applicable).
***Adults** will receive a comprehensive examination, a full mouth series of x-rays, periodontal assessment and routine cleaning if oral health permits. If oral health does not permit a routine cleaning another appointment will be scheduled accordingly.

Below is a list of office policies all patients need to be familiar with.

1. Office records and x-rays are digital. If you have digital quality x-rays from another office you may have them e-mailed to the office at **huntfamilydental@gmail.com**. All x-rays must be received prior to your first appointment. Printed copies and/or faxes are NOT acceptable.
2. All orthodontic patients need to have their wires removed prior to all cleaning appointments.
3. Appointment reminders are sent as a courtesy via our automated system. Please be sure to provide an e-mail address and phone number for text messages.
4. As a courtesy to all our patients, those who arrive more than 10 minutes past their scheduled appointment time will be required to reschedule. We respect your reserved time and will do our best to see you promptly. However, we occasionally experience delays and ask that you please be patient.
5. A 24 hour cancellation policy is effective for all appointments. Failure to give a 24 hour notice may result in a fee being charged to you. Fees are based on the length of the appointment.
6. **DO NOT** bring children with you to your appointment that are not able to sit unattended in the reception room. Only the patient receiving treatment is allowed in the operatory.
7. A copy of your records/x-rays are available upon request. A completed release form and any associated fees are required prior to the release of information.

_____ _____

Patient Name Date

_____ _____

Signature
(Patient or Responsible Party)

Relationship to Patient

# Hunt Family Dental Care

## Financial Policy

Dr. Adam Hunt welcomes you to our facility. We strive to provide you with exceptional care and our goal is to make your visit as convenient as possible.

**By Signing below you confirm that you have read this policy and understand the following:**

- It is your responsibility to inform our office of any contact information change including: address, email or phone number changes.
- We request your account be kept current. All self-pay or insurance co-payments, co-insurance and deductibles will be collected at the time of service. Payable by cash, check, credit card and care credit.
- If you do not have payment at the time of service your appointment will be rescheduled.
- A return check will result in a $35 service charge and all future payments will be requested in the form of cash or a credit card at the time of service.
- If your account is turned over to a collection agency, you will be responsible for any additional costs incurred in collection of said balance, which may include collection agency fees, court costs and attorney fees.
- Senior Citizens (age $\geq$ 65), who do not have dental insurance, will receive a courtesy discount of 10%

**Dental Insurance Coverage**

We are glad to submit your claims, however we emphasize that as dental providers, our relationship is with you, not your insurance company. Although we attempt to verify your insurance benefits, please be advised this is only an estimate of your coverage based on information provided to us at the time of inquiry.

**By signing below you confirm that you have read this policy and understand the following:**

- It is your responsibility to inform us of any insurance policy changes prior to your appointment.
- Authorizations are not a guarantee of payment.
- All service may not be covered under your insurance plan.
- It is your responsibility to be aware of what service or services are being provided to you and if it is covered under your insurance plan.
- You are responsible for all and any covered and non-covered charges payable by your insurance company.
- Filing your insurance claim is a courtesy extended to you; all charges are always your responsibility from the date services are rendered.
- You may be billed directly if your insurance plan does not provide payment in an appropriate time frame.

We realize that temporary financial problems arise and may affect timely payment. We urge you to contact our office immediately for assistance in the management of your account. We are here to assist you, please do not hesitate to ask for assistance.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____

Patient Name (Print) Date

_____ _____

Signature (Patient/Responsible Party) Relationship to Patient

## Hunt Family Dental Care

Adam C. Hunt, DMD

### Authorization of Use and Disclosure of Protected Health Information

1. The information covered by this authorization includes:
   - Appointments, Account and Treatment Information
2. Authorization is given to Hunt Family Dental Care to disclose information as indicated above.
3. My personal information may be discussed with and disclosed to the following individuals:
   - Please list any individual that may contact our office on your behalf such as a spouse, child, sibling, ect.

_____

Name of Person - Relationship

_____

Name of Person – Relationship

_____

Name of Person - Relationship

This authorization is effective one year from today unless revoked or terminated by the patient or patient's personal representative.

You may revoke or terminate this authorization by submitting written revocation to Hunt Family Dental Care.

Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The Privacy of this information may not be protected under the federal privacy regulations.

_____ _____

Patient Name (Print) Date

_____ _____

Signature (Patient/Responsible Party) Relationship to Patient

## Hunt Family Dental Care

Adam C. Hunt, DMD

## Treatment Consent Form

What you are being asked to sign is a confirmation that we have discussed the nature and the purpose of dental treatment, the known risks associated with dental treatment, and the feasible treatment alternatives, and that you have been given an opportunity to ask questions and all your questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand. My signature on the bottom of this form certifies that:

1. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.

2. I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.

3. I understand that the estimate given to me is for normal and usual treatment. I understand that if my treatment requires extra time, additional procedures or additional laboratory work, there will be additional fees related to the additional time and treatment.

4. I understand that Dr. Hunt has carefully examined my mouth. Alternatives to the chosen treatment have been explained. I have been informed and I understand the purpose and the nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of the prostheses.

5. I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.

6. I have been informed of the possible risks and complications involved with dental treatment that include but are not limited to: root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.

7. I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth and/or roots, difficulties in chewing and/or speech. Also, possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

8. Dr. Hunt has explained that there is no method to accurately predict the outcome of dental treatment due to large variations in teeth, gums, bone, chewing forces, and oral hygiene. It has been explained to me that in some instances dental treatment may not be successful.

9. I agree to follow the home care instructions provided to me. I agree to report to Dr. Hunt for regular examinations as indicated and I understand that this office will monitor my oral health.

10. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, any blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

11. I consent to photography, study models and X rays of the procedure to be performed for use in teaching dentistry and other graphic purposes.

12. I understand that with any dental treatment, my teeth, gums or bone can be damaged by bacteria and I must do my utmost to remove the bacterial plaque off all the surfaces of all my teeth and/or implants every day. If I do not clean my teeth and/or implants properly, I may get decay and/or gum disease and my treatment may fail. I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment.

_____ _____

Patient Name Date

_____ _____

Signature Relationship to Patient

(Patient/Responsible Party)

# PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

## Responsible Party ( if someone other than the patient )

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

### Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

### Section 3

Emergency Contact

Emergency #

Primary Care Doctor

Doctor #

Cardiologist

Cardiologist #

## Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

## Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Hunt Family Dental Care

# Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

| | | |
|---|---|---|
| Are you under a physician's care now? | ◯ Yes ◯ No | If yes |
| Have you ever been hospitalized or had a major operation? | ◯ Yes ◯ No | If yes |
| Have you ever had a serious head or neck injury? | ◯ Yes ◯ No | If yes |
| Are you taking any medications, pills, or drugs? | ◯ Yes ◯ No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | ◯ Yes ◯ No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ◯ Yes ◯ No | If yes |
| Are you on a special diet? | ◯ Yes ◯ No | |
| Do you use tobacco? | ◯ Yes ◯ No | |
| Do you use controlled substances? | ◯ Yes ◯ No | If yes |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Penicillin | ☐ Codeine | ☐ Acrylic |
| ☐ Metal | ☐ Latex | ☐ Sulfa Drugs | ☐ Local Anesthetics |

Other? ☐ If yes

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | High Cholesterol ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Breathing Problems ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Osteoporosis ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pacemaker ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| | | | Yellow Jaundice ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____