HUBBARD
DENTAL
LASER - FAMILY - COSMETIC

Patient Intake Form

First Name _____ Last Name_____ MI _____

Preferred Name _____ Gender _____ Birthday _____

Home Phone _____ Mobile Phone_____

Work Phone _____ Email _____

Address _____

_____

Emergency Contact _____ Phone _____

Preferred Pharmacy _____

Physician's Name _____

Are you financially responsible for this account? Please Circle Yes No

If you answered No, please fill out the below information:

Responsible Party First and Last Name _____

Responsible Party Phone Number _____

Do you have Dental Insurance? Please Circle Yes No

If yes, please fill out information below and provide front desk staff with card.

Name of Insurance Company _____

Name of Subscriber _____ Date of Birth _____

How did you hear about us? _____

Patient/ Guardian Signature _____

Relationship to patient _____

Medical History

First Name _____ Last Name_____ MI _____

Preferred Name _____ Gender _____ Birthday _____

Medical Conditions:

☐ * PRE MED	☐ Ablation	☐ Acid Reflux
☐ ADHD	☐ AFib	☐ Aids or HIV Infection
☐ ALS	☐ Alzheimer's	☐ Amnesia
☐ Anemia	☐ Anxiety	☐ Art. Heart Valve
☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Back Surgery	☐ Basal Cell	☐ Bell's Palsy
☐ Bleeding Disorder	☐ Blood Clots	☐ Blood Disease
☐ Blood Pressure – High	☐ Blood Pressure – Low	☐ Brain Surgery
☐ Brest Cancer	☐ Bronchiectasis	☐ CAD
☐ Cancer	☐ Cardiac Pacemaker	☐ Chemo/Radiation
☐ Cholesterol	☐ Circulatory Problems	☐ Congenital heart defect
☐ COPD	☐ Deep Vein Thrombosis	☐ Dementia
☐ Depression	☐ Diabetes	☐ Dysarthria
☐ Easily Winded	☐ Edema	☐ Ehlers-Danlos Syndrome
☐ Emphysema	☐ Epilepsy/ Convulsions	☐ Fainting/ Seizures
☐ Fibromyalgia	☐ Gallbladder Surgery	☐ GERD
☐ Glaucoma	☐ Gout	☐ Graves Disease
☐ Hashimoto thyroiditis	☐ Headaches	☐ Heart Arrhythmia
☐ Heart Attack	☐ Heart Disease	☐ Heart Failure
☐ Heart Murmur	☐ Heart Stent	☐ Heart Transplant
☐ Heart Trouble	☐ Heart Valve Replace	☐ Hepatitis/ Jaundice
☐ Herpes	☐ Hip Replacement	☐ Hypokalemia
☐ IBS	☐ Infective Endocarditis	Jaw Pain/ TMJ
☐ Joint Replace/ Implant	☐ Kidney Disease	☐ Mitral Valve Prolaps
☐ Leukemia	☐ Liver Disease	☐ Melanoma
☐ Multiple Sclerosis	Neck Surgery	☐ Osteoporosis
☐ Pacemaker	☐ Pancreas disorder	☐ Parkinson's Disease
☐ Past Endocarditis	☐ Pregnant	☐ Pulmonary Disease
☐ Pulmonary Fibrosis	☐ Pulmonary Embolism	☐ Rheumatoid Arthritis
☐ Shortness of Breathe	☐ Sinus Problems	☐ Skin Cancer
☐ Sleep Apnea	☐ Squamous Cell	☐ Stenosis of the Aortic Valve
☐ Stents	☐ Stomach problems/ Ulcers	☐ Stroke
☐ Thyroid Problems	☐ Tonsilitis	☐ Tuberculosis
☐ Ulcerative Colitis	☐ Vasovagal syncope	☐ Vertigo
☐ Wegener's Syndrome	☐	☐

Do you have any other Medical Conditions not list? Please circle Yes No

If yes, please specify any other medical conditions _____

_____

Allergies:

☐ Aleve	☐ Amoxicillin	☐ Apples
☐ Aspirin	☐ Augmentin	☐ Avelox
☐ Bee Stings	☐ Benadryl	☐ Avelox
☐ Cefdinir	☐ Ceftin	☐ Ciprofloxacin
☐ Clindamycin	☐ Codeine	☐ Diazepam
☐ Doxycycline	☐ Epinephrine	☐ Erythromycin
☐ Gluten	☐ Imitrex	☐ Iodine
☐ Keflex	☐ Latex	☐ Levaquin
☐ Lisinopril	☐ Local ANES	☐ Motrin
☐ Nitrous Oxide	☐ NSAIDS	☐ Oxycodone
☐ Peanut	☐ Penicillin	☐ Sedatives
☐ Shrimp/ Shellfish	☐ Steroid Shots	☐ Sulfa Drugs
☐ Tetracycline	☐ Xylitol	☐

List any other allergies not listed above: _____

Please List all medications, vitamins, and supplements you are taking _____

_____

Have you even been hospitalized or had a major surgery? Please Circle Yes No

If yes, please explain_____

Have you ever had a serious head or neck injury? Please Circle Yes No

Are you taking or have you ever taken medications for osteoporosis? Yes No

Do you use tobacco products? Circle Yes No

Do you drink alcoholic beverages? Circle Yes No

Do you use controlled substances? Circle Yes No

Have you ever taken a diet drug such as Fen-Phen? Circle Yes No

Women: Do you take any birth control medication? Circle Yes No

Women: Are you pregnant or do you think you may be pregnant? Yes No

Women: Are you Nursing? Circle Yes No

Is there any other information about your health we should know? _____

_____

Dental History

How long ago was your last visit to your dentist? _____
Name of previous dentist _____
How did you find us? _____
What is your reason for your visit today? _____
Have you ever had a bad experience at the dentist? Circle Yes No
Have you had any complications following a dental treatment? Circle Yes No
Have you had any unfavorable reactions to dental anesthetic? Circle Yes No
Does dental treatment make you nervous? Circle Yes No
Are your teeth sensitive to cold or hot temperatures? Circle Yes No
Do your gums bleed when you brush or floss? Circle Yes No
Do you grind your teeth? Circle Yes No
Are you aware of any sores or irritated areas in the mouth? Circle Yes No
Have you ever been treated for Periodontal Disease? Circle Yes No
How often do you brush? _____
How often do you floss? _____
Do you like your smile? Circle Yes No

If you could change your smile, what would you change?

- ☐ Change the color of my teeth
- ☐ Close spaces or restore worn out or broken teeth
- ☐ Change the shape of my teeth
- ☐ Change the position of alignment of my teeth
- ☐ Other: _____

I am interested in:

- ☐ Teeth whitening
- ☐ Cosmetic evaluation
- ☐ Replacement of missing teeth
- ☐ Straight Teeth
- ☐ Home Care
- ☐ Other: _____

To ensure your visit is a great experience, please share any questions of concerns you would like us to know about: _____

_____

HIPAA & Notice of Privacy Policy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Signature _____ Date_____

<u>Additional Family Members/ Guardians</u>

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____
4. _____ Relationship _____

HUBBARD
DENTAL
LASER - FAMILY - COSMETIC

Consent for Services and Financial Policy

First Name _____ Last Name_____ MI _____

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time the services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration of the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breech of any time or condition hereunder shall not constitute a waiver for any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you and your assignee to telephone me to discuss this statement or my treatment.

By Signing, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Consent for Services and Financial Policy.

Patient Signature: _____

Date: _____

HUBBARD
DENTAL
LASER · FAMILY · COSMETIC

Office Cancellation/ No Show Policy

Our goal is to provide quality dental care in a timely manner. In order to do so, we have had to implement an appointment/cancelation policy. This policy enables us to better utilize available appointments for our patients.

1. Cancellation/ No Show Policy

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book.

   A "no show" is someone who misses an appointment without canceling within 24- hour working day in advance. No-shows inconvenience those individuals who need access to dental care in a timely manner. If you need to cancel due to a COVID-19 exposure, please notify our office immediately.

2. How to Cancel Your Appointment

   If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely dental care. To cancel an appointment, please call our office during normal business hours. You can cancel via email within a 24-hour work day.

3. Scheduled Appointments

   We understand that delays can happen, however, we do our best to keep other patients and our doctors on time. If you are running late, please notify the office. If a patient is 15 minutes late past their scheduled time, we may need to reschedule your appointment, which could incur a same day cancellation fee.

   The Following Charges are for services in the office:
   Same Day Appointment Cancellation: $50.00
   No-Show Fee: $50.00 Returned Check Fee: $25.00

   Patient Name: _____ Signature: _____

   Date: _____

HUBBARD
DENTAL
LASER - FAMILY - COSMETIC

155 Turnberry Way Pinehurst, NC 28374 Phone: (910) 695-3050 Fax: (910) 695-3054

Record Release Form

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

Previous Dental Office or Future Dentist:

Office/Doctor :_____

Phone: _____ Fax: _____

Address: _____

Please Provide a copy of recent dental records and/or radiographs.
(Bitewing and Periapical X-rays within 1 year and Panorex X-ray within 5 years)

Please forward my requested dental x-rays to:

Hubbard Dental

Email: Jhubbarddental@gmail.com

Please include dates x-rays were taken. Thank you

I understand that my express consent is required to release any healthcare information relating to my dental care. I hereby consent to the release radiographs to the above dental office/ Doctor.

Signature: _____ Date: _____

Relationship if signed by someone else (Parent, Legal Guardian): _____