Welcome to Hodge Family Dentistry

PATIENT INFORMATION/HEALTH HISTORY

Patient Information **Date _____**

Name _____ Name you wish to be called: _____
(last) (first)

Gender: female ☐ male ☐ Birth Date _____Soc. Sec # _____Marital Status_____

Driver License #_____

Address _____City/St/Zip_____

E-mail Addr_____Home Phone_____ Cell Phone_____

Employer _____ Work Phone _____ Emer Phone_____

What number do you prefer we contact you on? Circle one: Home / Work / Cell and the best time to call you?_____

How did you hear about our office? Circle one: Website / Insurance Co List / Yellow Pages / Referred by:_____

Emer. Contact name:_____Relationship:_____Phone _____

If married please complete the following:

Name of Spouse: _____ Birthdate: _____ Soc. Sec: _____

Spouse's Employer: _____Work Phone: _____ Other Phone: _____

PRIMARY DENTAL INSURANCE

Insurance Co Name _____

Subscriber Name _____

Relationship to Patient _____Group # _____

Employer_____

Subscriber ID# _____

SECONDARY DENTAL INSURANCE

Insurance Co Name_____

Subscriber Name_____

Relationship to Patient _____Group # _____

Employer _____

Subscriber ID# _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Brandi Hodge, D.D.S.,P.A. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I have had full opportunity to read and consider the contents of the Notice of Privacy Practice for Hodge Family Dentistry. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature of responsible party _____**Date** _____

A good doctor/patient relationship is based on open communications. Our office staff will answer any questions you may have now or in the future. We look forward to providing you with exceptional dental care.

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____
City, State _____ How often do you brush? _____
Date of Last Dental Visit _____ How often do you floss? _____

Please check all that apply to your dental concerns:

- ☐ Bleeding Gums
- ☐ Tooth Pain
- ☐ Loose Teeth
- ☐ Broken Fillings
- ☐ Jaw joint pain
- ☐ Jaw joint Clicking
- ☐ Grinding Teeth
- ☐ Pain around Ear
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Frequent Headaches
- ☐ Blisters on Lips/ in Mouth
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Cold
- ☐ Sensitivity when Biting
- ☐ Sensitivity to Sweets
- ☐ Dissatisfied with color and/or crowding of teeth
- ☐ Wisdom Teeth
- ☐ Bad Breath
- ☐ Do you have missing teeth you want replaced

MEDICAL HISTORY

Physician's Name _____Date of Last Medical Exam _____Blood Pressure _____

Have you had any allergic reactions to the following:

Local anesthetics (e.g. Novocain) ☐ yes ☐ no Codeine ☐ yes ☐ no Latex ☐ yes ☐ no
Penicillin ☐ yes ☐ no Sulfa ☐ yes ☐ no List any others_____

Have you taken Bisphosphonates (i.e. Fosamax)_____Do you use tobacco products _____ use alcohol____

Are you taking any type of blood thinner? _____ If, yes please list _____

(Women Only) Are You: Pregnant _____ Nursing _____ Taking birth control pills _____

Are you currently under medical treatment? For? _____

Are you currently taking any medication? If so please list:_____
_____

Please list any serious illness or operations _____

_____

Please check all that apply to your medical information:

- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Blood Disease
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Depression
- ☐ Emphysema/COPD Respiratory Problems
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ HIV/AIDS/ Venereal Disease
- ☐ Hepatitis Type?___
- ☐ Heart Problem/Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Jaw, Head or Neck Injuries
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Swelling Feet/Ankle
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer

Other medical conditions or concerns please list: _____

_____

Signature_____Date_____

FINANCIAL POLICY

Hodge Family Dentistry
Brandi Hodge, DDS
2112 West Main Street
Russellville, AR 72801
(479) 968-7314

We hope the following summary of our financial policy helps you understand what we expect from you in return for the quality care you will receive.

- **Initial visit for a new patient**, payment is required regardless of insurance coverage. Unless prior approval was given.
- **Your Insurance** is ultimately between you and your employer/insurance company. We will do everything we can to help you maximize your insurance benefits.
    - In order for us to do this you must provide our office with your insurance identification number which maybe your social security number or employee id, the name of your insurance company, their phone, and mailing address, as well as that of your employer so we will be better equipped to estimate your co-pay at each visit.
    - At each visit, you will be responsible for paying the estimated portion your insurance will not cover.
    - If payment is not received from your insurance carrier within 60 days from date of service, you will be responsible for any balance due.
    - As a courtesy to you, if extensive treatment is required a pre-determination claim can be filed with your insurance company. This will give you a more definitive estimate of your co-pay.
- **Any fees** not covered by your insurance are your responsibility and need to be paid at each visit, unless prior payment arrangements have been made. Payment arrangements/plans are available for extensive treatment. Payment plans must be discussed and approved before treatment with our financial counselor.

A good doctor/patient relationship is based on open communications. Our office staff will answer any questions you may have now or in the future. We look forward to providing you with exceptional dental care.

I have read and understand this financial policy and agree to the instructions therein.

Signature: _____ Date: _____
(Signature of the person responsible)