PATIENT INFORMATION/HEALTH HISTORY

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

Patient Information

Date _____

Name _____ Name you wish to be called: _____

Soc. Sec # _____Birth date _____ Sex: female ☐ male ☐

Address _____City/St/Zip_____

Home Phone_____ _ Emer Phone_____

Whom may we thank for referring you? _____

Relative not living at the same address:_____Phone _____

FATHER'S INFORMATION:

Name _____Soc Sec# _____Birthdate_____

Employer _____Work Phone_____Home Phone_____

Email Address_____Cell Phone _____

MOTHER'S INFORMATION:

Name_____Soc Secc#_____Birthdate_____

Employer_____Work Phone_____Home Phone_____

Email Address _____Cell 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	□ Jaw joint pain	□ Orthodontic Treatment	□ Sensitivity to Heat
□ Tooth Pain	□ Jaw joint Clicking	□ Periodontal Treatment	□ Sensitivity to Cold
□ Loose Teeth	□ Grinding Teeth	□ Frequent Headaches	□ Sensitivity when Biting
□ Broken Fillings	□ Pain around Ear	□ Blisters on Lips/ in Mouth	□ Sensitivity to Sweets
□ Dissatisfied with color and/or crowding of teeth		□ Wisdom Teeth	□ Bad Breath

MEDICAL HISTORY

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

Have you had any allergic reactions to the following:

	YES	NO
Local anesthetics (eg. Novocaine)	□	□
Penicillin	□	□

Are you currently under medical treatment?____
_____
_____

Please list any others. _____Have you taken Bisphosphonate (i.e. Fosamax)_____

Please list any serious illness or operations _____

_____

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

_____

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

Do you use tobacco products _____ use alcohol____

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

Please check all that apply to your medical information:

□ Artificial Joints	□ Cancer	□ Rheumatic Fever	□ Epilepsy
□ AIDS	□ Chemotherapy	□ Glaucoma	□ Emphysema
□ HIV Positive	□ Radiation Treatment	□ Shortness of Breath	□ Fainting or Dizziness
□ Hepatitis Type?_____	□ Tuberculosis	□ Bleeding Problems	□ Kidney Disease
□ Diabetes	□ Asthma	□ Anemia	□ Liver Disease
□ Heart Problems	□ Pacemaker	□ Psychiatric Care	□ Thyroid Problems
□ Low Blood Pressure	□ Stroke	□ Arthritis, Rheumatism	□ Venereal Disease
□ High Blood Pressure	□ Heart Murmur	□ Sinus Trouble	□ Jaw, Head or Neck Injuries
□ Artificial Heart Valves	□ Mitral Valve Prolapse	□ Ulcer	□ Swelling of Feet/Ankle
□ Congenital Heart Lesions	□ Circulatory Problems	□ Blood Disease	

□ Other medical conditions or concerns please list: _____

_____

Office use:
Health history updates_____

_____

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)