Hammer Dental Associates

Patient Information

Name:____________________________Birthdate____-____-____Social Sec#____-____-____

Address___________________________City_________________State_________Zip_________

Home Phone:______________________Email Address:_________________________________

Cell Phone:______________________ Emergency Contact Name:_______________________

Work Phone:______________________Emergency Contact Phone:_______________________

Employer:_________________________Occupation:____________________________________

Whom May We Thank For Referring You?____

Dental Insurance Information

Name of Insured:__________________Relationship:_______Birth of Insured:____-____-____

Social Sec#:_______-_______-_____ Member ID#:____________________________________

Insurance Company:_______________Group#:____________Employer:____________________

Patient Medical History

Physician/Practice Name:________________________Office Phone:_______________________

Date of Last Medical Exam:__________________Date of Last Dental Exam:________________

Are You Under Medical Treatment Now?_________________________Blood Pressure:_________

Are You Taking any Medications? If yes, List:_____________________________________

Are You Allergic to Any Medications or Latex?____________________________________

Do You Have Any Medical Problems? ____

Are You Pregnant or Think You Are?____ Are You Nursing?____ Are You Taking Birth Control Pills?____

Authorization, Release, and Financial Policy

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answer. I understand that providing incorrect information can be dangerous to my health. I authorize Hammer Dental to release and obtain any information including x-rays, the diagnosis and records of any treatment rendered to myself or dependents myself the period of such dental care to third-party payers and other health practitioners. I authorize and request my insurance company to pay directly to Hammer Dental any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I acknowledge of receipt of notice of privacy practices and a copy is available at the office and online at www.hammerddds.com . Any missed appointment with out notification is subject to a fee of $100. ***I agree to be responsible for full payment of all services rendered on my behalf or my dependence, including any collection fees if necessary. Accounts over 60 days are subject to a 2% interest rate/per month, 24% per year and if handed to a collection service a 40% fee will incur.*** *Rev 5/19*

X____**Date:**__________________

Signature of patient (or parent if minor)