

## Welcome to Hadley Family Dentistry

We are excited to welcome you and your family to our dental practice. At any time feel free to ask questions. At Hadley Family Dentistry we want your experience to be a good one. Let us know if you have any special concerns about your dental treatment. It is no surprise to us that the dental office is not everyone's favorite place to visit. Our goal is to change that opinion.

Our office is open Monday through Thursday. In case of a dental emergency, our phones are answered 24 hours a day. Should our voicemail system answer your emergency call it is important to leave a call back number so your call may be returned.

As a courtesy, we will file your insurance for you. Any estimation given is not a guarantee of payment, and is based on the information supplied by your insurance company. We strive to be as accurate as possible, however; your insurance benefits are your responsibility and the total fee is your balance. We offer many different payment options. We offer Care Credit, which is a dental/medical credit line that can be used in other offices that accept it. They have interest-free payment plans. Uninsured patients receive a 10% discount when paying with cash the day of their appointment.

We offer a wide range of dental services. Cleanings, non-surgical gum treatment, white bonded fillings, crowns, bridges, cosmetic veneers, root canals, implant retained restorations, dentures, partials, and whitening to name a few. We offer such a wide range of services to our patients because we understand it takes time to become comfortable with a dental office. Therefore, unless it is in your best interest, we want you to be treated here; where you are comfortable.

If you could please answer these few questions it would help us better serve you.

What did you like or dislike about your last dental office?

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What is your main dental concern for today's visit?

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Circle any of the following that you are interested in learning about.

Whitening      Tooth colored fillings      Custom characterized dentures/partials

Implant Services      Invisalign      Same day crowns      Other \_\_\_\_\_

Please rate how you feel on the appearance of your smile: Circle your answer.

I like it very much      I like it      It's okay      I would like to change it

## Patient Information Form

### Patient Information

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we contact in case of an emergency? Name \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to us? Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Financial Information

Person responsible for the account: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_ SS #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of the insured: \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Employer: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Name of the insured: \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Employer: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information included in this packet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if minor)

\_\_\_\_\_  
Date

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics
- Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_

**Hadley Family Dentistry**  
**Financial Responsibility Statement**  
**And**  
**Consent For Treatment**

We realize that the financial aspects of healthcare are often confusing and can sometimes be intimidating. We will do our best to help make this as understandable as possible. As long as we are provided with accurate and current insurance information, we will file charges with your primary and/or secondary insurance companies. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of your insurance plans. Each one has different stipulations regarding how often services may be rendered, and even more importantly, who may provide those services. It is therefore very important for you to bring proof of coverage (ID cards or insurance forms) to your appointment. Please review our process for insurance coverage below so that you have all relevant information at the time of your appointment. A 48 hour notice is required for all cancellations or there may be a \$32.50 failed appointment Fee on your next statement. Thanks for valuing our time so we can better serve you.

1. Verify whether or not we are a participating provider for your insurance plan.
2. Is there a co-pay or deductible with your insurance coverage? Be prepared to pay that amount in full the day of your appointment.
3. If you call our office, we can provide for you an estimate of payment due the day of your appointment.
4. As a courtesy, we will submit the initial claim to your insurance company.
5. You will receive a statement as long as your account has a balance.
6. If payment from your insurance company does not cover all charges, because of unpaid deductibles, coinsurance, or non-covered services, you will be responsible for any amount remaining on your account.
7. Any finance charges, refilling fees, collection charges, or attorney fees may be added to an overdue balance.

If you do not have insurance coverage or when non-covered services are performed:

1. Please call our office to obtain an estimate of charges for the services provided for your appointment.
1. When you pay in full the day of the appointment, you will receive a 10% discount.
2. We accept Visa, MasterCard, Care Credit, checks, and cash

I have read and understand the financial statement above, and agree to accept financial responsibility as described.

Consent for treatment:

The undersigned hereby authorizes Dr. Hadley or designated staff members to take necessary radiographs, study models, photographs, or any other diagnostic aids required to make a comprehensive diagnosis of existing conditions. I further authorize Dr. Hadley or designated staff members to perform any and all forms of treatment, including administering of medications and delivery of therapy that may be indicated. I also assign all insurance benefits to Dr. Hadley. Please note that our HIPPA policy is available for your review upon request. A copy of the policy is also displayed in our reception area.

I have read and understand the financial statement above, and agree to accept financial responsibility as described. I have also read and understand the consent for treatment as described above, and agree to be bound as described.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date