



HOBBS
DENTISTRY

Hobbs Dentistry
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Welcome to our Practice!

We are delighted that you have selected our office for your dental care.

To assist us in providing you with excellent service, please take a few minutes to print the enclosed forms and complete them prior to your arrival.

You may also fax the completed forms to us if that is more convenient.

Please do not hesitate to call us if we can answer any questions about these forms or your first visit with us.

We look forward to meeting you!

Sincerely,
Dr. Rebecca Hobbs & Team



HOBBS
DENTISTRY

Welcome!



Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible care. To help us meet your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PATIENT INFORMATION

Name _____ I like to be called _____ Age _____
Birthdate _____ Phone _____ Cell _____ Work Phone _____
Gender M F Marital Status: Minor Single Married Divorced Widowed Separated
Social Security# _____ Spouse name/ Parent if child _____
Address _____ City/State/Zip _____
Who may we thank for referring you? _____
Can we send you text message or email appointment reminders? Yes No Email _____
Emergency Contact _____ Emergency Phone _____ Relationship to Patient _____
Is another member of your family a patient at this office? Yes No
If yes, please provide their Name(s) and Relationship _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____
Phone _____ Cell _____ Employer _____ Work Phone _____
Social Security# _____ Email _____ Birthdate _____
Address _____ City/State/Zip _____

INSURANCE INFORMATION • Primary

Name of Insured _____ Relationship to Patient _____
Social Security# _____ Birthdate _____
Employer _____ Employer Address _____
Date Employed _____ Employer Phone _____
Insurance Company _____ Group # _____ Ins. Co. Phone _____
Ins. Co. Address _____ City/State/Zip _____
Yearly Deductible \$ _____ Max. Annual Benefit \$ _____ How much have you used this year? \$ _____
Do you have a secondary dental insurance plan? Yes No *If yes, please complete the following:*

INSURANCE INFORMATION • Secondary

Name of Insured _____ Relationship to Patient _____
Social Security# _____ Birthdate _____
Employer _____ Employer Address _____
Date Employed _____ Employer Phone _____
Insurance Company _____ Group # _____ Ins. Co. Phone _____
Ins. Co. Address _____ City/State/Zip _____
Yearly Deductible \$ _____ Max. Annual Benefit \$ _____ How much have you used this year? \$ _____

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ABOUT YOU

Employer _____

No. of Years Employed _____

Occupation _____

Position _____

Business Address _____

City/State/Zip _____

Phone _____

Other _____

ABOUT YOUR SPOUSE

Employer _____

No. of Years Employed _____

Occupation _____

Position _____

Business Address _____

City/State/Zip _____

Phone _____

Other _____

CONSENT FOR TREATMENT

- I attest that to the best of my knowledge the information provided is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next visit following the change. In addition I authorize the Doctor or his representative to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations.
- I also authorize the Doctor to perform all forms of treatment, medication, and therapy that may be indicated, and further authorize and consent that the Doctor choose and employ such assistance as she deems fit. I understand that the use of anesthetic agents embodies a certain risk.
- I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made in advance.

PLEASE PRINT PATIENT'S NAME _____ DATE _____

SIGNATURE _____

SIGNED BY
 PATIENT PARENT GUARDIAN

Welcome to Hobbs Dentistry!

To help us better serve your child's dental needs, please take a moment to answer the following questions about their health:



Patient Name _____ Date of Birth _____
Guardian's Name _____ Relationship to Patient _____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Date of most recent exam _____ Purpose of visit _____

Does your child have any health problems? Yes No

If so, please list: _____

Does your child have any allergies to any medications (ie penicillin) or latex? Yes No

If so, please list: _____

Does your child have any other allergies? Yes No

If so, please list: _____

Has your child ever had a serious illness or been hospitalized? Yes No

If so, please describe: _____

Has your child ever had surgery or are any surgeries planned? Yes No

If so, please describe: _____

Is your child taking any prescribed or over-the-counter medications? Yes No

If so, please list: _____

Does your child have a history of any of the following? (Please circle all that apply.)

- | | | | | |
|---------------------------|--------------------------|--------------------|-------------------------------|----------------------------|
| Asthma | Hepatitis | Mental Retardation | Heart Problems | AIDS/HIV |
| Eye Problems | Liver Problems | Fainting/Dizziness | Speech Impairments | Kidney Problems/Infections |
| Seizures/Epilepsy | Hearing Loss | Lung Problems | Infections | Diabetes |
| Rheumatic Fever | Tuberculosis | Heart Murmur | Cerebral Palsy | Nervous Disorders |
| Prolonged/Severe Bleeding | Congenital Birth Defects | Growth Problems | Behavioral/Learning Disorders | |

DENTAL HISTORY Is this your child's first dental visit? Yes No If not, when was the last visit? _____

Has your child ever had an unfavorable dental experience? Yes No

If so, please describe: _____

My child brushes his/her teeth: upon rising after every meal before going to bed

Has your child ever suffered any injuries to the head, mouth, or neck? Yes No

If so, please describe: _____

What type of water does your child drink? City Well Bottled Filtered

Please list any concerns that you have about your child's dental health. _____

- Yes No Has your child ever received local anesthetic?
- Yes No Does your child eat between meals?
- Yes No Has your child had protective sealants placed on his/her teeth?
- Yes No Has your child ever had any teeth extracted (baby or adult)?
- Yes No Has your child had cavities diagnosed in the past?
- Yes No Does your child use toothpaste containing fluoride?

I certify that the information provided is complete and correct.

SIGNATURE OF PARENT/GUARDIAN

DATE _____

HOBBS DENTISTRY PATIENT AGREEMENT

We are committed to providing you with the best possible care. In order to achieve these goals, we ask for your assistance and your understanding of our financial and scheduling policies.

Financial Policy

Payment for services rendered is due and payable at the time of treatment unless arrangements have been made in advance. We accept Cash, Personal Checks, American Express, Visa, Mastercard.

We have an agreement with CareCredit®, a third party financing company, which may afford you the opportunity to make monthly payments for your treatment. CareCredit® offers low interest plans to qualified applicants. Please inquire if you are interested in applying.

Minor Children: The parent or guardian that brings a minor child in for treatment in our practice is responsible for payment for services.

Administrative Fees and Interest: There is a \$30 service charge for returned checks. Account balances that are 30 days or more past due are subject to 1½% monthly interest (18% annual percentage rate (APR)). Any fees incurred during the collection of a past due account are the responsibility of the account guarantor.

Dental Insurance:

Dental insurance amounts are estimated coverage only; the patient/responsible guardian is responsible for amounts not covered or claims not paid within 60 days from date of service. Balances owed are subject to interest and collection practices of this office. Your estimated patient share of the fees is required at the time of service unless you have made arrangements prior to treatment.

Secondary Dental Insurance Coverage: We do not file claims with secondary insurance plans in our practice; we will provide you with the necessary information to file these claims to reimburse you directly. Any financial arrangements made in our practice will be based on primary coverage only.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

Appointment Policy:

We do not double-book appointments in our office, and request 2 business days' notice for all cancellations of appointments. Broken appointments or late cancellations of appointments are subject to a \$50 fee.

We ask for your cooperation in managing your appointments so that we can maintain the highest level of access to care possible at all times for each of our valued patients.

I have been informed of Hobbs Dentistry financial and appointment policies. I agree to be responsible for all fees for services and materials incurred during the course of my treatment. To the extent permitted by law I consent to your use of my protected health information to carry out payment activities in connection with my care. I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to Hobbs Dentistry.

Signature of Patient or Responsible Party

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to Sign this Acknowledgement****

I have received a copy or have been given access to the Hobbs Dentistry Notice of Privacy Practices. I give my permission to Hobbs Dentistry to:

- Communicate with other health care professionals and dental insurance carriers (if applicable) as needed throughout the course of my care.
- Leave messages for me at my contact numbers provided and mail, email or text reminders to me (unless I decline one of these options in writing) regarding appointment dates and times.

PATIENT OR PARENT/GUARDIAN SIGNATURE

DATE