Hulsey Dentistry New Patient Registration Form – Adult

GENERAL INFORMATION:

First Name_____ Last Name_____ Middle Initial _____ Preferred Name _____ ○ Male ○ Female

Birthday_____ Age_____ Soc. Sec._____ Drivers Lic._____

Address_____ City_____ State_____ Zip_____

Cell #_____ Home #_____ Other #_____

Email_____ Would you like to receive correspondence via email? ○ Yes ○ No

****Would you like appointment reminders via Text? ○ YES ○ NO**

○ Married ○ Single ○ Divorced ○ Separated ○ Widowed Spouse Name_____

Employer_____ Occupation_____

Employment Status ○ Full Time ○ Part Time ○ Retired How long have you lived in this area?_____

Preferred Pharmacy_____ Primary Doctor_____

Emergency Contact_____ Phone_____ Relationship_____

Responsible Party Name *(if other than patient)*_____

How did you hear of our office?_____

Signature_____ Date_____

DENTAL INSURANCE INFORMATION:

Primary Dental Coverage Information

Dental Insurance Company_____ Dental Insurance Phone_____

Dental Insurance Address_____

Policy ID Number_____ Group ID Number_____

Subscriber Name_____ Relationship to patient ○ Self ○ Spouse ○ Parent ○ Other_____

Subscriber Employer_____ Soc. Sec._____ Birth Date_____

Secondary Dental Coverage Information

Dental Insurance Company_____ Dental Insurance Phone_____

Dental Insurance Address_____

Policy ID Number_____ Group ID Number_____

Subscriber Name_____ Relationship to patient ○ Self ○ Spouse ○ Parent ○ Other_____

Subscriber Employer_____ Soc. Sec._____ Birth Date_____

Hulsey Dentistry Medical History Form

	YES	NO
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatments?	☐	☐
Have you had any problems with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐

	YES	NO
Do you have earaches or neck pain?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had a serious injury to your mouth?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐

Date of your last X-rays _____

Date of your last dental exam _____ Previous Dentist _____

PLEASE READ.

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions that you have/have had and medications that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

CURRENT/PREVIOUS MEDICAL HISTORY

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Have you ever:		
Been hospitalized/had major surgery?	◯ Yes ◯ No	If yes
Had a serious head or neck injury?	◯ Yes ◯ No	If yes
Used tobacco (currently or in past)?	◯ Yes ◯ No	If yes
Taken Fosamax, Boniva, Actonel or any other bisphosphonate medication?	◯ Yes ◯ No	If yes
WOMEN ONLY:		
Are you pregnant? If yes, when is your due date?	◯ Yes ◯ No	If yes
Trying to get pregnant?	◯ Yes ◯ No	If yes
Nursing?	◯ Yes ◯ No	If yes
Taking birth control pills or hormonal replacement?	◯ Yes ◯ No	If yes

MEDICATIONS

Please list ALL current medications (or we will gladly make a copy):

PREMEDICATE

Do you currently have or have you ever had any of the following:

An orthopedic total joint replacement (hip, knee, elbow, finger) -- if yes, date? Any complications?	◯ Yes ◯ No	If yes
Artificial (prosthetic) heart valve	◯ Yes ◯ No	If yes
Previous infective endocarditis	◯ Yes ◯ No	If yes
Damaged heart valves in transplanted heart	◯ Yes ◯ No	If yes

Congenital Heart Disorder (CHD)

Unrepaired, cyanotic CHD	◯ Yes ◯ No
Repaired (completely) in last 6 months	◯ Yes ◯ No
Repaired CHD with residual effects	◯ Yes ◯ No

OTHER (See "Comments" section below) ◯ Yes ◯ No

ALLERGIES

Are you ALLERGIC to any of the following:

Acrylic	Yes No	Aspirin	Yes No	Barbiturates	Yes No
Codeine	Yes No	Hydrocodone	Yes No	Latex	Yes No
Local Anesthetics	Yes No	Nickel	Yes No	Penicillin	Yes No
Sedatives/Sleeping Pills	Yes No	Sulfa Drugs	Yes No	OTHER (See "Comments" section below)	Yes No

CONDITIONS

Please check ALL that apply.

AIDS / HIV Positive	Yes No	Alzheimer's Disease/ Dementia	Yes No	Anaphylaxis	Yes No
Angina	Yes No	Arthritis / Gout	Yes No	Asthma*	Yes No
				Anemia	Yes No

Autoimmune Disorder:

Addison's	Yes No	Celiac Sprue	Yes No	Crohn's	Yes No
Graves'	Yes No	Hashimoto's	Yes No	Lupus	Yes No
Psoriasis	Yes No	Reactive Arthritis	Yes No	Rheumatoid Arthritis	Yes No
Scleroderma	Yes No	Sjogren's	Yes No	Ulcerative Colitis	Yes No
OTHER (See "Comments" section below)	Yes No				

Conditions (continued)

Back Pain*	Yes No	Blood Disease	Yes No	Blood Transfusion	Yes No
Bruise Easily	Yes No	Cancer	Yes No	Cardiovascular Disease*	Yes No
Chest Pains	Yes No	Cold Sores / Fever Blisters	Yes No	Congestive Heart Failure*	Yes No
				Breathing Problems	Yes No
				Chemotherapy	Yes No
				Cortisone Medicine	Yes No

Diabetes:*

Type 1	Yes No	Type 2	Yes No

Conditions (continued)

Drug Addiction	Yes No	Epilepsy / Seizures*	Yes No	Excessive Bleeding*	Yes No	Excessive Thirst	Yes No
Excessive Urination	Yes No	Fainting Spells / Dizziness	Yes No	Frequent Cough	Yes No	Frequent Diarrhea	Yes No
Frequent Headaches	Yes No	Glaucoma	Yes No	Hay Fever	Yes No	Heart Attack*	Yes No
Heart Murmur	Yes No	Heart Pacemaker*	Yes No	Heartburn / Reflux	Yes No	Hemophilia	Yes No
Hepatitis A	Yes No	Hepatitis B or C*	Yes No	High Blood Pressure*	Yes No	High Cholesterol	Yes No
Hives or Rash	Yes No	Hypoglycemia	Yes No	Irregular Heartbeat	Yes No	Kidney Problems	Yes No
Leukemia	Yes No	Liver Disease	Yes No	Low Blood Pressure	Yes No	Lung Disease / COPD / Emphysema*	Yes No
Mitral Valve Prolapse	Yes No	Osteoporosis	Yes No	Parathyroid Disease	Yes No	Psychiatric Care	Yes No
Radiation Treatments*	Yes No	Recent Weight Loss	Yes No	Renal Dialysis	Yes No	Rheumatic Fever	Yes No
Scarlet Fever	Yes No	Sexually Transmitted Disease	Yes No	Shingles	Yes No	Sickle Cell Disease	Yes No
Sinus Trouble	Yes No	Spina Bifida	Yes No	Stomach / Intestinal Disease	Yes No	Stroke*	Yes No
Swelling of Limbs	Yes No	Swollen glands in neck	Yes No	Thyroid Disease	Yes No	Tonsillitis	Yes No
Tuberculosis	Yes No	Tumors / Growths	Yes No	Ulcers	Yes No	OTHER (See "Comments" section below)	Yes No

ADDITIONAL COMMENTS

Please use this section for further explanation/other comments, or if you answered "Other" to any question above:

PATIENT ACKNOWLEDGEMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my (or patient's) health. It is my responsibility to inform dental personnel of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Text or Call 770-532-6004
1943 Jesse Jewell Pkwy. Suite 600 Gainesville, GA 30501

OFFICE POLICIES

FINANCIAL POLICY

Our Hulsey Dentistry team is dedicated to providing the exceptional care that you deserve at a price that is fair, clearly discussed, and easy to manage. For your convenience, we offer a range of payment options and we can be easily reached with any question you may have about our financial policies. We will be sensitive to your financial circumstances and do everything possible to help you achieve optimal oral health.

PAYMENT OPTIONS- We gladly accept Cash, Personal Check, All major Credit Cards and Flex Benefits Cards. We also offer payment options with CareCredit (subject to credit approval). You may apply for this special financing via a CareCredit link on our website.

FOR PATIENTS WITHOUT INSURANCE- We require payment in full at the time of treatment, unless prior arrangements have been made. Additionally, for patients without dental insurance, we offer a New Patient Discount as well as an in-house savings plan called HD SMILE CLUB. Regardless of age, employment, or dental needs, you and your family are invited to join this membership plan. See a Hulsey Dentistry team member for details.

FOR PATIENTS WITH INSURANCE- We require payment in full of your estimated out-of-pocket, co-pay or deductible at the time of treatment, unless prior arrangements have been made. We are not contracted with any dental insurance company; we are considered an out-of-network provider. We will gladly verify, file, and collect payment from most dental PPO insurance companies. Be advised that any amounts proposed to be paid by insurance companies are estimates only, and that no guarantee can be made by our office regarding these amounts. In the event that the amount paid by your carrier differs from the estimate, you will be billed for the difference. Please be aware your insurance is a contract between you, the insurance company and your employer and you are ultimately responsible for any amount not paid by your insurance. While we go to great lengths to both verify and understand the many details of your specific dental policy, your insurance will never guarantee a payment.

RETURNED CHECKS- If a Personal Check is returned, a $25.00 returned check fee will be charged to your account to cover the bank's processing fees.

PAST DUE ACCOUNTS – Itemized statements representing the patient responsibility portion of your account balance are generated and mailed approximately every thirty (30) days. Patient account balances are due IN FULL within fifteen (15) days of the statement date. If you have received three (3) statements and have not paid your patient account balance in full nor have you made a payment arrangement with our office, your account will be considered delinquent. Delinquent patient accounts may be forwarded to a collection agency. Patient accounts forwarded to a collection agency will be charged for all costs and expenses associated with the collection of your account including, but not limited to, our reasonable attorneys' fees. Additionally, if your account is forwarded to a collection agency, you may be dismissed from the practice due to a failed professional relationship.

MINORS - Please make payments to the office in advance if someone other than the parent/guardian will be bringing your child to the appointment**.**

DIVORCE AND SEPARATION – The parent/guardian who brings the child to their dental visit is responsible for payment independent of who carries the insurance or a divorce decree. Reimbursement must be made between the divorced parents. We will not intervene.

PLEASE INITIAL _____

APPOINTMENT POLICY

CANCELATION AND MISSED APPOINTMENT POLICY - A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. Dr. Hulsey and our team spend extensive amounts of time preparing for your visit. In order to maintain the integrity of our schedule, we must hold strictly to the following standards:

- We require 48 hours notice for any cancellation or rescheduling of your appointment.
- Failure to provide 48 hours notice on any missed appointment may be subject to a $50.00 missed appointment fee.
- Repeated cancellations or missed appointments may result in loss of future appointment privileges.

PLEASE INITIAL _____

INSURANCE POLICY

INSURANCE CHANGE - We ask that you provide all NEW or CHANGED dental insurance information PRIOR to the day of your appointment. Since we require your out-of-pocket to be paid in full at the time of service, we will need to verify the benefit details prior to your appointment. If NEW information is presented at the time of service and we're unable to verify these NEW benefits, you'll be expected to pay in full for the services rendered.

INSURANCE PAYMENT - Should your Insurance Company accidentally send the payment to you rather than us, you agree to forward this payment to Hulsey Dentistry within 10 days of receiving the payment.

INSURANCE USED AT ANOTHER OFFICE – Please be aware you must inform us when you use your dental coverage at another dental office.

I authorize payment of my dental benefits to be made directly to Hulsey Dentistry. **PLEASE INITIAL _____**

HIPAA PRIVACY POLICY

Hulsey Dentistry has a privacy policy in effect that you are welcome and entitled to view. Please notify the Front Desk if you wish to have a copy.

PLEASE INITIAL _____

I understand and agree to the office policies explained above.

Print Name_____ **Signature**_____ **Date**_____