

Welcome

ABOUT YOU

Today's Date _____

Name: _____ I prefer to be called: _____ Male Female
Last First MI Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security # _____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ Pager/Car # (____) _____ Work Phone #: (____) _____ Ext. _____

Email address: _____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there: _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone # (____) _____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext. _____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext. _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthday: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthday: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

ABOUT YOU

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you need to be premedicated before dental treatment? Yes No

Have you experienced problems associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is Good Fair Poor

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? Yes No

If yes, what? _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____
Street City State Zip

Phone #: (____) _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Are you allergic to any of the following:

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs that cause allergic reactions: _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week # _____ Are you nursing? Yes No

Are you taking any of the following:

Acetaminophen <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Thinners <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin/Diabetes Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Nitroglycerin <input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers <input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamines <input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Remedies <input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	
Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	Digitalis/Heart Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Steroids/Cortisone <input type="checkbox"/> Yes <input type="checkbox"/> No	

If yes, how often and how many milligrams? _____

Are you taking any prescription / over-the-counter drugs not listed above? Yes No If yes, please list each one: _____

Do you or have you experienced the following:

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Stroke
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Pacemaker	Y N Thyroid Problems
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Persistent Cough	Y N Tonsillitis
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Psychiatric Problems	Y N Tuberculosis (TB)
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Ulcers
Y N Cancer	Y N Fever Blisters	Y N HIV+ / AIDS	Y N Rheumatic Fever	Y N Venereal Disease
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any Reason	Y N Scarlet Fever	
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature

Date

INSURANCE

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

Signature

Date

PAYMENT IS DUE AT TIME OF SERVICE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dr. Brian W. Hazen, D.M.D.

410 Lake Bridge Plaza Dr. Ormond Beach, FL 32174

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

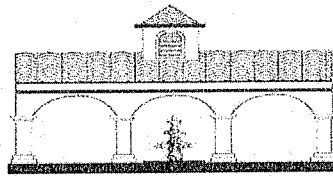
FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

Employee signature

Date



BRIAN W. HAZEN, D.M.D.

RESTORATIVE & COSMETIC DENTISTRY

410 Lakebridge Plaza Drive Ormond Beach, FL 32174 Phone: 386-672-3988

INSURANCE FILING POLICY

INSURANCE IS NEVER GUARANTEED

Dr. Brian W. Hazen's office will be glad to take assignment on your insurance provided we obtain the following information from you prior to your appointment: (Email: hazenfrontoffice@cfl.rr.com ; Fax: 386-672-2663)

- Copy of your insurance card and your photo identification
- Insurance Company Name, Group # and mailing address
- Insurance Company Phone number
- Insured's Name, Social Security Number & Date of Birth
- Employers Name and Phone Number

This Information must be updated every year, usually in January, and will be required from you each year or we will be unable to file your insurance.

Insurance is **NEVER GUARANTEED**. You are responsible for all debt incurred at this office. We will file Claims ONLY TWICE. Our office responds to all requests sent to us from your insurance company (x-rays, narratives, etc.) If a request is sent to you for other coverage, or full time student verification, it is your responsibility to respond to the insurance company. If payment is not made by your insurance company 90 days after our office has filed the claim twice, the full balance is due by the person responsible for the account. We will be glad to provide you with any and all information regarding the date of service that your insurance company did not pay, to help you collect from them.

If there is an overpayment, reimbursement may be required by the insurance company, otherwise the insured is reimbursed.

Your signature on this form is required indication you have read and understand this policy.

Signature

Date