Kyle T. Hunt, D.M.D.

971 Lakeland Drive, Suite 952
Jackson, MS 39216

Patient Information Form

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name _____ Preferred name _____ Birth date_____ Age _____

Mailing address _____ City _____State _____ Zip _____

Email address: _____ SS#: _____

Driver's License # _____ Marital Status: Δ *Married* Δ *Divorced* Δ *Widow* Δ *Single*

Home phone _____ Cell Phone _____Work phone _____

Employer _____ Occupation _____

Is patient a student? _____ If yes, FT or PT? _____ School Attending: _____

Whom may we thank for referring you to our office? _____

Who will be responsible for your account: _____ Relation: _____

Date of Birth: _____SS# _____ Driver's Lic # _____

Phone: _____ Email: _____

Mailing Address: _____ City _____ State _____ Zip _____

Place of Employment: _____Work Phone: _____

Spouse or Other Guarantor Information (If different from above)

Name: _____ Relation: _____ SS# _____

Date of Birth: _____ Phone: _____

Mailing Address: _____ City _____ State ____ Zip _____

Employer: _____ Work Phone: _____

BILLING AND INSURANCE INFORMATION:

Primary Dental Insurance

Employer: _____ Business Telephone: _____

Ins Co Name: _____ ID#_____

Address: _____ City _____ State _____ Zip_____

Tel (___) _____ Group Name: _____ Group #_____

Insured Party _____ Relation _____ Date of Birth _____ Sex:_____

SS# _____

Primary Medical Insurance

Employer: _____ Business Telephone: _____

Ins Co Name: _____ ID#_____

Address: _____ City _____ State _____ Zip_____

Tel (___) _____ Group Name: _____ Group #_____

Insured Party _____ Relation _____ Date of Birth _____ Sex:_____

SS# _____

Signature of patient (or parent/guardian) _____ **Date** _____

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Medical History Questionnaire

Patient Name: _____ Date of Birth: _____

Weight: _____

Emergency Contact Information:

Name: _____ Phone: _____

Please answer the following questions by circling "YES" or "NO"

1. Do you have a sore throat or cold at the present time? _____ YES NO
2. Have you ever been hospitalized for an operation or illness? _____ YES NO
3. Other than checkups, have you been under the care of a physician during the past two years? YES NO
4. Are you taking any medication or drugs at the present time or have Taken any medication or drugs in the past two years? YES NO
   Please list: _____
   _____
5. Are you allergic or sensitive to any substance (pollen, foods, soaps, etc.?) _____ YES NO
6. Are you allergic to any drug or medicine (penicillin, sulfa, codeine, local Anesthetic, etc.)? YES NO
   If so, please list: _____
   _____
7. Have you experienced excessive bleeding from a cut or injury, surgery, or tooth extraction? YES NO
8. Have you ever had radiation or cobalt treatments of the head, neck, face or other areas of the body? YES NO
9. Do you have a surgical implant such as a prosthetic heart valve or artificial joint? _____ YES NO
10. (Women): Are you pregnant? YES NO
11. Do you smoke? _____packs/day for _____ years YES NO
12. Do you use smokeless tobacco? _____# pouches/day_____#cans/day YES NO
13. Do you drink alcohol? Light _____ Moderate _____ Heavy _____ YES NO
14. Do your wear contact lenses? YES NO
15. **Please circle the following conditions that you have either experienced or been treated for:**

Congestive Heart Failure (Weakened Heart)	Emphysema	Swollen Ankles
Heart Attack (Coronary)	Pneumonia	Shortness of Breath
Congenital Heart Defects	Tuberculosis	Chronic Cough
Heart Murmur	Liver Disease (Hepatitis)	Asthma
Rheumatic Fever	Jaundice	Anemia
Irregular Heart Beat or Pulse	Diabetes	Fainting
High Blood Pressure	Arthritis	Kidney or Bladder Infection
High Cholesterol	Stroke or paralysis	Venereal Disease
Psychiatric Counseling or Treatment	Epilepsy or Seizures	Thyroid Condition (High or Low)

16. Have you ever taken medications for osteoporosis (injectable or oral) or Chemotherapy for cancer? YES NO
    If so, please list medications: _____
    _____
17. Do you have any other condition or problem not listed above? YES NO
    If so, please describe: _____
    _____
18. Do you consider your health - Good _____ Fair _____ Poor _____

Patient/Guardian Signature: _____ Date: _____

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FINANCIAL POLICY

Welcome! Thank you for selecting us for your oral and maxillofacial surgical care. Our goal is to provide you and your family with optimal oral surgical care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions.
This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Patients are expected to pay for our services at the time they are rendered. Our patients who have insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, Mastercard and/or Discover. We also offer CARECREDIT, a financing option available only for health care expenses. We will mail monthly statements to all patients with an outstanding balance charge of 1.5% per month or 18% per annum after 90 days.

Optional payment terms:

By arrangements with CARECREDIT, we can offer patients upon approval, an interest-free term loan (up to 18 months) with no down payment, no annual fee and no prepayment penalty. Ask for an application or apply online.

There will be a fee for any additional procedure NOT included in the original treatment plan.

Appointments:

In order to serve you better and keep the cost of oral surgical care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24 hour notice for any canceled appointment. After 3 missed appointments or canceled appointments you will be dismissed as a patient.

Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit, as well as anytime your insurance changes. Because

oral surgery is sometimes covered by medical insurance, we will need copies of both your dental and medical insurance coverage.

We will diagnose treatment based on your oral health, not your insurance coverage.

You must realize that:

Dental and/or medical insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental and/or medical services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary treatment. It is important to know that some procedures are NOT covered by insurance.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. **The insured has a better ability to deal with the insurance company and the employer responsible for the policy.**

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient/Guardian Name (Please Print) _____

Signature of Patient/Guardian _____ **Date** _____

KYLE T. HUNT, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____