



Please review and add missing information & make any corrections needed.

Patient Name: _____
Address: _____ City: _____ State _____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone _____
Employer: _____ Insurance Company: _____
Email Address: _____

Have you had any of the following? Please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart murmur/mitral Valve | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Cancer or tumor | <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive(AIDS) | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Tuberculosis (TB) |

If checked - please explain: _____

Current medications: _____

Drug Allergies - Please list: _____

Recent surgeries: _____

Who is your medical doctor?: _____ Phone: _____

In the event of an emergency, who should we contact?: _____

Phone: _____ Cell: _____ Work: _____

Health Insurance Portability and Accountability Act Consent

Due to the health insurance portability and accountability act, our office is now required to give all patients the ability to obtain a copy of our privacy policy. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office reception room for patients to review. Please sign this as your acknowledgement that this office is following HIPPA policy.

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment, activities, and healthcare operations. You have a right to read our Notice of Privacy Practices before you decide whether to sign this consent. You will have the right to revoke this consent at any time by giving us written notice of your revocation by certified mail.

In Order to Insure the accuracy of your protected health information, it is our policy to update this form annually.

I authorize Dr. Sandi Hamm to release my dental or insurance information as necessary to process my dental claims and coordinate or manage my dental care. In the event of a family member or caregiver attends my dental visit and is in the exam room at the time of my evaluation or treatment, I give Dr. Sandi Hamm and her staff members my permission to discuss freely, my condition, treatment, or diagnosis with that person. YES / NO

Home Phone: May we leave a message? YES / NO Work Phone: May we leave a message? YES / NO

Cell Phone: May we leave a message? YES / NO Email: _____ May we leave a message? YES / NO

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or her staff. I agree to pay for all services rendered by this office.

Date: _____ Signature: _____ Relationship to patient: _____