Precise Family Dental
Dr. Melissa Precise Hamilton, DMD

Patient Information

Name:_______________ DOB:__________ SSN:__________

Address:_______________ City:__________ State:____ Zip:______

Phone:__________ Work: __________ Cell:__________

Please Circle: **Preferred Phone: Home/Work/Cell** Text: **Yes No** Email: __________

Circle Appropriate: Minor Single Married Widowed Separated Divorced

Spouse or Parent's Name: _______________ Phone: __________

How did you hear about our office? Friends/Family Facebook Drove by Other______

Emergency Contact

Name:_______________ Relation:__________ Phone:__________

Responsible Party

Relationship to Patient: Self Spouse Parent Other

Name:_______________ DOB:__________ SS#__________

Address:_______________ City:__________ State:____ Zip:______

Phone:__________ Employer:_______________ Work Phone:__________

Insurance Information

Name of Insured:_______________ DOB:__________ SS#__________

Relationship to Patient:_______________ Employer:_______________

Insurance:__________ Group#:__________ ID#__________

Secondary Insurance

Name of Insured:_______________ DOB:__________ SS#__________

Relationship to Patient:_______________ Employer:_______________

Insurance:__________ Group#:__________ ID#__________

Patient Medical/Dental History

Primary Care Physician:________________________________ Phone:______________________

Date of Last Exam:___________ Are you under medical treatment now?______________

Do you have regular dental check-ups? ____________ Date of last Dental Exam: __________

Do you floss? _______ How often? _______ How many times/day do you brush your teeth? _____

Reason for seeking dental care today? _____________Any pain or discomfort now? __________

PLEASE CHECK ALL THAT APPLY: Present or Past Conditions

___ AIDS/HIV
___ Alcohol Abuse
___ Allergies
____Seasonal
____Specific Allergy
___ Anemia
___ Asthma
___ Arthritis
___ Bleed Easily
___ Bleeding Gums
___ Cancer/Tumor
Type: ___________
Year Diagnosed: _____
___ Chest Pain- Angina
___ Cocaine Abuse
___ Congenital Heart Defect
___ Diabetes
Type: __________
___ Emphysema
___ Epilepsy/Seizures
___ Face/Mouth Trauma
___ Glaucoma

___ Grinding of Teeth
___ Gum Surgery
___ Heart Attack
Year:______
___ Heart Disease
___ Heart Murmur
___ Hepatitis/Liver Disease
___ High Blood Pressure
Regular BP ____/____
___ Illegal Substance Abuse
___ Dental Implant
___ Jaundice
___ Joint Replacement
Where: ______
Year:_______
___ Kidney Disease
___ Leukemia
Type: _______
___ Low Blood Pressure
Normal:______
___ Mitral Valve Prolapse
___ Pregnant
Due Date:________

___ Psychiatric Care
Condition: __________
___ Radiation Therapy
When: __________
___ Recent Rapid Weight Loss
___ Rheumatic Fever
___ STD
Type: ___________
___ Shortness of Breath
___ Stomach Ulcer
___ Stroke
When: _________
___ Swollen Ankles
___ Tobacco Usage
___ Thyroid Disease
___Hypo
___Hyper
___ Other-Specify
____
____
____

Current Medications/Condition taking for:

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

ARE YOU ALLERGIC TO OR HAD A BAD REACTION TO ANY OF THE FOLLOWING:

____ Local Anesthetic ____ Latex ____ Penicillin
____ Other Medications – Specify: ________________________________
____ Shellfish/Shrimp ____ Other Foods-Specify: ____________________
____ Other Allergies- Specify: ___________________________________

Insurance and Financial Policy

At **Precise Family Dental**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding care to hundreds of patients. Some have dental benefits, but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

- Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- We currently accept many private care insurance plans. This means that we work with literally hundreds of companies. Although we can maintain computerized histories of payment given by a company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee coverage. This does delay treatment but will give you the exact out-of-pocket figures you may require.
- We will bill your insurance as a courtesy. If insurance does not pay within 90 days, **Precise Family Dental** reserves the right to request payment in full for services from you and let you collect the insurance funs that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. In the event collection action has to be taken regarding this account, the undersigned agrees to accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection fees, (33.33%), attorney fees, and/or court costs, if such be necessary. Ultimately, you are responsible for all charges incurred in our office.
- **Precise Family Dental** does require full payment in full for your portion at the time of service. We accept most major credit cards, cash, and personal checks. You agree, in order for us to service your account or to collect monies you may owe, Precise Family Dental and/or our collection agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices as applicable. Returned checks will be charged a fee of **$30 per check**.

Cancellation Policy

A Specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a $35 per hour per patient cancellation fee.

I agree with the above conditions:

Signature: ______________________________ **Date:** ____________________

Health Information Privacy Protection Act (HIPPA)

Effective April 14, 2003 new federal law requires physicians and health care providers to obtain written consent before disclosing your personnel health information to other health care professionals or facilities. Please know that complete confidentiality is a priority of the highest magnitude in our office. However, in the course of providing optimal care for you it may be necessary to disclose diagnoses or lab results to other physicians or facilities directly related to your care. A copy of this policy is available at your request.

I agree with the above conditions:

Signature: ______________________________ **Date:** ____________________