10011 S Centennial Pkwy, Ste 540
Sandy, UT 84070
801-255-7645

1070 W Horizon Ridge Pkwy, Ste 120
Henderson, NV 89012
702-449-4835

Hamblin Dental Welcomes You to Our Office

Please feel confident that all information provided is confidential

Personal Information

Please print

Name_____ Birth Date_____

Home Address_____

City_____ State_____ Zip_____

Male Female Single Married Name of spouse_____

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

How can we contact you?

Home Phone_____ Work Phone_____ ext._____

Cellular Phone_____E-mail_____

Responsible Party

Name_____ Relationship to patient_____

Birth Date_____ Drivers License #_____

Insurance Information: Copy on file? Yes _____ No _____

Insurance Carrier_____ Subscriber Name_____
D.O.B._____

Authorization and Release

I authorize the dental staff to perform any dental services that I agree to during diagnosis and treatment, including the use of local anaesthetic, and will assume responsibility for payment of all services rendered on my behalf or my dependents, regardless of insurance.

*I authorize Dr. Hamblin or his employees to release any information concerning my dental treatment, or my child's, to third party payers and/or health practitioners.

Financial Disclaimer

I/We agree to pay all attorneys fees, court costs, filing fees, and all collection costs. I am aware that up to 50% of amount owing may be assessed by any collection agency retained to pursue the matter. I/We further agree to pay interest at the rate of one and one half percent per month (eighteen percent per year) or a minimum of $5.00 on the unpaid balance.

Signature of patient or parent of minor _____ *Date*_____

Medical History

Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. This information is very important. Thank you in advance for your cooperation.

Medications

•What medications are you taking, including "over the counter", i.e. aspirin, vitamins, etc.?

_____ _____

_____ _____

_____ _____

•Are you allergic to anything? Penicillin Codeine Latex Other_____

Have you ever had any of the following diseases or medical problems?

Heart Problems

•Your normal blood pressure _____/_____

Heart Murmur Stroke Heart Attack

Pace Maker Rheumatic Fever Angina

Heart Valve

Do you take antibiotics for dental appointments? Periodontal disease and dental infections may increase the risk of Stroke and Coronary Heart Disease.

Bleeding

•Do you bleed easily? (Aspirin can cause this.)

Yes No

•Are you on Coumadin or other blood thinners?

Yes No

•Do you have Hepatitis? Yes No

A B C D Jaundice

Diabetes

•Do you have Diabetes? Yes No

Type 1 Type 2 Latest HbA1c Score ____%

Recent studies have shown a link between Diabetes and Periodontal Disease. It is important to your health that they both are under control. The warning signs of Diabetes are frequent trips to the bathroom, thirsty all the time, and always feeling hungry.

Breathing/Lungs

Sinus problems Seasonal Allergies Bronchitis

Asthma Snoring

Is it hard to breathe normally through your nose?

Pregnancy (Women Only)

•Are you pregnant? Yes No

•Are you taking birth control pills? Yes No

Antibiotics can interfere with birth control pills by causing them not to work. Periodontal infections can increase the risk for low birth weights in newborns. This is very dangerous!

Cancer

•Do you have cancer? Yes No

•Have you ever had cancer? Yes No

•When?_____

•What kind?_____

•How are you being or were you treated?

Surgery Chemotherapy Radiation

General Questions

•Do you smoke? Yes No How many packs/day?_____

•Do you have a Mental Health Disorder?

Yes No What is it?

_____

Nerves/Muscles/Bones

•Do you have back problems? Yes No

•Can you lie in a dental chair comfortably?

Yes No

•Do you have a Neuromuscular Disorder?

Yes No
What is it?
_____

Immune System
•Lupus Organ Transplant HIV AIDS
ARC

Anything else you think we need to know about the systems of your body? _____

Past Dental Experiences

What have you disliked about past dental experiences?

Was the treatment uncomfortable?
Was the staff unfriendly?
Were the fees or financial policy not explained prior to your appointment?
Anything else?_____
_____

What can we do to make you feel more comfortable?

Would you like to be reminded of your appointments?
Would you like a personal Walkman or CD player to listen to during your appointment?
Will you need a blanket to help with temperature control?
Will you need a pillow to support your neck during treatment?
Would you like to wear sunglasses during your appointment?
Would you like nitrous oxide or a sedative while being treated?

Front Teeth
Are you happy with their color? Yes No
Are you happy with their length? Yes No
Are they crowded or crooked? Yes No
Are braces an option? Yes No
Are you happy with their overall appearance? Yes No
Anything about them you would like to change?_____

Back Teeth
Are they sensitive to hot or cold foods? Yes No
Do they trap food when you eat? Yes No
Anything about them you would like to change? _____

Gums
Do they bleed? Yes No
Are they sensitive? Yes No
Do you have bad breath? Yes No

Missing Teeth
Do you have any missing teeth? Yes No
Are you wearing a tooth replacement? Yes No
If you wear a denture or partial, is it comfortable? Yes No
Have you considered dental implants? Yes No

Do you have any dental implants? Yes No
Is this appointment for a second opinion? Yes No

What is the first thing you would like us to help you with? _____

_____

Consent for treatment

I, the undersigned, certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information.

Signature of patient or parent of minor _____*Date*_____

Consent to Photograph

In our office we like to photograph our patients for aid in determining their problems and to help come up with the perfect treatment options for them. With these photographs, we can recreate your smile on the computer so that you can see the final results and approve of them before we start any procedure. Dr. Hamblin also uses the photographs with the patient's permission to teach dentists from all over the world how we create beautiful smiles for our patients.

*I _____, hereby authorize Dr. Scott Hamblin to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and /or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature of patient or parent of minor _____*Date*_____

HIPPA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from a third party payer
Conduct Normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature of patient or parent of minor _____*Date*_____