Wm. Todd Hamer, D.M.D. **Date: ____/____/_____**

Name:_____ **Preferred Name**:_____
First **Middle Initial** **Last**

Home Phone:( )_____ **Cell Phone**:( )_____

Address:_____**City:**_____ **State:**_____ **Zip**_____

Sex: □ M □ F **Age**_____ **Birthdate**: _____/_____/_____ □ **Single** □ **Married**

Patient Employed By: _____ **Email Address**: _____

Business Address: _____ Business **Phone**:( )_____

Who may we thank for referring you? _____

Other family members seen in our office: _____

In case of emergency who should be notified? _____ **Phone:**( )_____

Person Responsible for Account: _____

PRIMARY INSURANCE

Subscriber Name:_____
Last **First** **Middle Initial**

Relation to Patient: _____ **Birthdate:** _____/_____/_____ **ID#/SS#**_____

Address (if different than patient): _____

Insured Employed By: _____ **Business Phone:**( )_____

Insurance Company: _____ **Group #:** _____

Member ID/Subscriber #: _____

ADDITIONAL INSURANCE

Subscriber Name:_____
Last **First** **Middle Initial**

Relation to Patient: _____ **Birthdate:** _____/_____/_____ **ID#/SS#**_____

Address (if different than patient):_____

Insured Employed By: _____ **Business Phone:(**)_____

Insurance Company: _____ **Group #:** _____

Member ID/Subscriber #: _____

To the best of my knowledge all information is true and correct:

Signature: _____**Date:** _____

Health History

Name: _____ Physician Name: _____

Physician Phone #: ( )_____ Pharmacy Name & Number:_____

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

Mitral Valve Prolapse_____ Rheumatic Fever_____
Heart Murmur_____ Artificial Joints _____
Artificial Heart Valve_____ Radiation_____ Region_____

Anemia	_____	Low Blood Pressure	_____
Arthritis	_____	Lung Disease	_____
Blood Disease	_____	Kidney Disease	_____
Taking Blood Thinners	_____	HIV/Aids	_____
Cancer	_____	Latex Reaction	_____
Chemotherapy	_____	Local Anesthetic Reaction	_____
Convulsions	_____	Nervous Disorder	_____
Diabetes	_____	Pacemaker	_____
Epilepsy/Seizure	_____	Pregnant _____	Due Date: _____
Excessive Bleeding	_____	Taking Oral Contraceptives?	_____
Fainting	_____	Respiratory Problems	_____
Heart Attack	_____	Stroke	_____
Heart Disease	_____	Tumors	_____
Hepatitis	_____	Thyroid Problems	_____
High Blood Pressure	_____	Osteoporosis	_____
		Taking Meds for Low Bone Density/Osteoporosis	_____

Have you ever had any complications following dental treatment: Yes/No If yes, explain?

_____

Do you or have you ever had any disease, condition, or problem not listed:

_____

Have you ever had to use an antibiotic for premedication before dental treatment? Yes/No If yes, explain:

_____

Have you been ill or needed emergency care recently? Yes/No If yes, explain:

_____

List any/all medications prescribed/over the counter you are taking:

_____

_____

List any medications you are allergic to:_____

Do you use tobacco products/how often?_____

To the best of my knowledge this information is true and correct:
Signature: _____ **Date:** ____/_____/_____

Wm. Todd Hamer, D.M.D., P.C.
314 Bob Wallace Ave. S.W.
Suite B
Huntsville, AL. 35801
(256)533-0237

EXPLANATION OF OFFICE POLICY

All patients need to understand that all services furnished are charged directly to the patient and that he/she is responsible for the bill. As a courtesy to our patients, we will file to most insurance carriers. However, you must realize that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We cannot render services under the assumption that charges will be covered by your insurance company. We strive to provide the best dental treatment according to the patient's needs regardless of insurance coverage.

The patient/responsible party is required to pay an estimate of any deductibles and/or co-pays at each visit according to how your particular insurance plan specifies. Anything not paid by insurance for any reason immediately becomes due from the patient/responsible party. Our office finance charge is 18% for any outstanding balance.

*****There will be a $35 fee for any appointment that is cancelled or missed without a 24- hour notice. *****

PATIENT NAME: _____

I have read and understand the foregoing "Explanation of Office Policy." I hereby guarantee payment for dental services rendered to the above-named patient, this to include any and all future services, as well as those presently contemplated. I hereby authorize payment directly to Wm. Todd Hamer, DMD, PC for the benefits payable under the terms of my policy for any service and/or treatment provided**. I realize that all dental charges incurred by me or my dependents for services rendered by Wm. Todd Hamer DMD PC are my financial responsibility. I accept the fee charged as legal and lawful debt and agree to pay said fee, including collection agency fees, (33.33% for debts less than 12 months old, 40% for debts 12-36 months old, & 45% for debts 36-48 months old), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.**

RESPONSIBLE PARTY SIGNATURE: _____
DATE: _____

Wm. Todd Hamer, D.M.D., P.C.
314 Bob Wallace Ave. S.W. Suite B
Huntsville, AL 35801
(256)533-0237

PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE/E-MAIL

You agree, in order for us to service your account, confirm any dental appointments you or your dependents have or to collect monies you owe, Wm. Todd Hamer DMD, PC and/or our 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 e-mails, using any e-mail address you provide to us. Methods of contact may include pre-recorded/artificial messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Wm. Todd Hamer DMD, PC, its employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signature **Date**

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize W. Todd Hamer, DMD, PC to release to my insurance(s) full information, including copies of records and operative notes relative to my physical care/condition/treatment.

SIGNATURE: _____ DATE: _____

Wm. Todd Hamer, D.M.D., P.C.
314 Bob Wallace Ave. S.W.
Suite B Huntsville, AL. 35801

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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 third-party payers
*Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 above 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 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.

PATIENT NAME: _____

SIGNATURE OF PATIENT
or LEGAL GUARDIAN: _____

Date: _____

You may disclose my health information to the following persons:

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason
_____	_____	_____