HATHCOAT FAMILY DENTAL

1580 Mann Drive | Suite B | Pinole, CA 94564
phone: (510)724-5330 | fax: (510)724-1895
hathcoatfamilydental.com

PATIENT REGISTRATION INFORMATION

Today's Date _____

Personal

Last Name _____ First Name _____ MI _____ Date of Birth _____
Soc. Sec. # _____ Gender (birth): ☐ Male ☐ Female ☐ Other (specify): _____
Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widow

Mailing Address _____ City _____ State ____ Zip Code _____
Home Phone (_____)_____ Cell Phone (_____)_____ Email _____

Emergency Contacts

Emergency contact: Name _____ Phone # (_____)_____ Relationship _____
Nearest Relative: Name _____ Phone # (_____)_____ Relationship _____

Employment

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student (Full-Time) ☐Student (Part-Time) ☐Not employed
Employer _____ Occupation _____
Mailing Address _____ City _____ State ____ Zip Code _____
Work Phone (_____)_____x_____

Responsible Party (Complete this section if patient is a minor or you are a guardian)

Responsible Party Name _____ Relationship _____ Date of Birth _____
Soc. Sec. # _____
Home Phone (_____)_____ Cell Phone (_____)_____ Email _____

Employer _____ Occupation _____
Mailing Address _____ City _____ State ____ Zip Code _____
Work Phone (_____)_____x_____

Dental Insurance Information (Primary)

Insured's Name: _____ Insured's DOB: _____
Employer: _____ Insurance Co: _____
Group #: _____ Subscriber #: _____ Insurance phone: _____

Dental Insurance Information (Secondary)

Insured's Name: _____ Insured's DOB: _____
Employer: _____ Insurance Co: _____
Group #: _____ Subscriber #: _____ Insurance phone: _____

Referral Source

How did you hear about us? ☐ Insurance Co ☐ Internet Search ☐ Yelp! ☐ Facebook ☐ Google ☐ Practice Website
☐ Family/Friend/Coworker (Name: _____) ☐ Other_____

Communication

As we implement new technologies, we will introduce convenient methods for courtesy reminders and communication.
Please indicate your preferred methods of contact (mark all that apply). ☐ phone call ☐ text ☐ email

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ACKNOWLEDGEMENT AND CONSENT

Patient Name: _____ Birth Date: _____

Acknowledgement of Insurance Payment Authorization I authorize and direct payment of the dental insurance benefits for services rendered, otherwise payable to me, directly to Hathcoat Family Dental. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Hathcoat Family Dental.

Acknowledgement of Financial Responsibility I acknowledge I am fully responsible for paying all treatment related charges, missed appointment fees, and late payment fees. I understand payment is due at time of service unless previous arrangements are made.

Notice of Privacy Practices I acknowledge that I received and reviewed Hathcoat Family Dental's Notice of Privacy Practices, which describes the how the practice may use and disclose my protected healthcare information (PHI) for treatment, payment, operations, and other permitted uses. I understand that I may contact Hathcoat Family Dental with any questions or concerns. To the extent permitted by law, I consent to the use and disclosure of my PHI as described in the Notice of Privacy Practices.

Acknowledgement of Dental Materials Fact Sheet I acknowledge that I received and reviewed the Dental Materials Fact Sheet prior to consenting to any treatment at Hathcoat Family Dental. I have had my questions and concerns answered to my satisfaction.

Photography Consent: I consent for Hathcoat Family Dental to take treatment related photographs before, during, and after treatment. These photos may include headshot, extraoral (smile and teeth), and/or intraoral (tissue and teeth). These photographs may be used for evaluation, diagnosis, documentation, insurance, referral to other healthcare providers, patient education, and professional dental research and education. I understand that I will not receive any compensation for use of any photographs. I understand that any personal identifying information will be kept confidential. I understand that I may revoke this consent at any time, in writing, to Hathcoat Family Dental.

I hereby authorize Hathcoat Family Dental to release any and all relevant dental and medical information to any referring dentist, medical doctor, other healthcare provider, or insurance company. This information includes, but is not limited to records of examination, diagnosis, treatment, and prognosis.

SIGNATURE: _____ DATE: _____

If you are signing this form on behalf of another person, please provide the following information:

Name (Print): _____ Relationship _____

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Dental History

Patient Name: _____ Birth Date: _____

Welcome! Our goal is to customize your dental experience to best meet your needs and expectations. To accomplish this, we need to learn more about you and your dental health. Please complete this form to the best of your ability.

1. What is the main reason for your visit today? _____

2. Previous dentist: _____ Reason for changing dentist: _____
Date of last: cleaning/exam: _____, complete x-rays: _____, Oral Cancer Screening: _____

3. **On a scale of 1-10 (1-low, 10-high)**:

	Low									High
How important is your dental health to you?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Where do you want your dental health to be?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

4. What would you like to improve about your smile?

☐ Whiter Teeth ☐ Straighten ☐ Healthy Gums ☐ Replace Metal Fillings ☐ Mismatched Crowns
☐ Smile Makeover ☐ Chipped Teeth ☐ Close Spaces ☐ Replace Missing Teeth ☐ Reduce Crowding

5. How often do you:

	< 1x daily	1x Daily	2x Daily	> 3x Daily
Brush	☐	☐	☐	☐
Floss	☐	☐	☐	☐

Do you use other dental aids: ☐Waterpik ☐ toothpicks ☐ flossers ☐ Gum stimulator ☐ Proxabrush ☐Other

6. How would you rate your dental anxiety?

	Low									High
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

a. What causes your anxiety? ☐ Previous Bad Experience ☐ Needles ☐ Numbing ☐ Noise ☐ Cost
☐ Not knowing process ☐Other: _____

b. Previous comfort options: ☐ Nitrous Oxide ☐ Oral Sedation (Pill) ☐ IV Sedation ☐ Other: _____

7. Please mark any of the following oral/dental conditions you experience:

Appearance
- ☐ Discolored/yellow teeth
- ☐ Worn or misshaped Teeth
- ☐ Crooked / Crowding / Spaces
- ☐ Overbite / Underbite
- ☐ Broken teeth/fillings/crowns

Pain/Discomfort
- ☐ Tooth sensitivity (hot, cold, sweet)
- ☐ Pressure when biting or chewing
- ☐ Food caught between teeth
- ☐ Dry mouth
- ☐ Cold sores, blisters, other sores

Function
- ☐ Grinding / Clenching
- ☐ Jaw Joint (TMJ) pain/click/pop
- ☐ Pain opening/closing
- ☐ Pain chewing on one side
- ☐ Sore muscles (jaw/head/neck)
- ☐ Headaches

Gum Health
- ☐ Deep Cleaning / Gum Surgery
- ☐ Bleeding Gums
- ☐ Mouth Odors or bad taste
- ☐ Loose, tipped, shifting teeth

Habits
- ☐ Thumb sucking/Tongue thrust
- ☐ Nail Biting
- ☐ Cheek/Lip Chewing/Biting
- ☐ Ice Chewing
- ☐ Foreign objects (pens,pipe,nails,etc.)

Sleep Pattern or Conditions
- ☐ Sleep Apnea (CPAP, appliance)
- ☐ Snoring / Mouth breathing
- ☐ Sleep on multiple pillows

Social habits
- ☐ Tobacco/Nicotine(smoke,chew,vape)
- ☐ Alcohol

Patient/Guardian Signature: _____ Date: _____

RDH review: _____ DDS Review: _____ Date: _____

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CONFIDENTIAL MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

		Yes	No
1.	Have you been under the care of a medical doctor during the past two years? If yes, please describe: _____	☐	☐
2.	Physician's Name/Phone/Address: _____		
3.	Have you been a patient in the hospital during the past five years? If yes, please explain: _____	☐	☐
4.	Are you taking any medications, supplements, or vitamins? Please list name/dose: _____ _____	☐	☐
5.	Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐Penicillin/Antibiotics _____ ☐Sulfa Drugs ☐Anesthetics ☐Nitrous Oxide ☐Aspirin ☐Opioids/Sedatives ☐NSAIDs ☐Codeine ☐Latex ☐Other: _____	☐	☐
6.	Have you lost or gained more than 10 pounds in the past year?	☐	☐
7.	Have you taken antibiotics prior to dental treatment? Name/Reason: _____	☐	☐
8.	Have you ever taken medication to slow/prevent bone loss (osteoporosis)? Medication start date, name, and dose: _____	☐	☐

9. Have you experienced (past or present) any of the following conditions? Mark "Yes" or "No".

	Yes	No		Yes	No		Yes	No
Heart (Surgery,Disease,Attack)	☐	☐	Diabetes	☐	☐	Hepatitis A B C (Circle)	☐	☐
Chest Pain	☐	☐	Thyroid Problems	☐	☐	S.T.D. _____	☐	☐
Congenital Heart Disease	☐	☐	Kidney Trouble	☐	☐	H.I.V.	☐	☐
Heart Murmur	☐	☐	Liver Disease	☐	☐	A.I.D.S.	☐	☐
High Blood Pressure	☐	☐	Jaundice	☐	☐	Cold Sores/Fever Blisters	☐	☐
Mitral Valve Prolapse	☐	☐	Asthma	☐	☐	Blood Transfusion	☐	☐
Artificial Heart Valve	☐	☐	Allergies/Hives	☐	☐	Hemophilia/Excessive Bleeding	☐	☐
Heart Pacemaker	☐	☐	Hay Fever	☐	☐	Sickle Cell Disease	☐	☐
Rheumatic Fever	☐	☐	Sinus Trouble	☐	☐	Bruise Easily	☐	☐
Scarlet Fever	☐	☐	Tuberculosis	☐	☐	Glaucoma	☐	☐
Stroke	☐	☐	Chronic Cough	☐	☐	Contact Lenses	☐	☐
Cortisone Medicine	☐	☐	Emphysema/COPD	☐	☐	Psychiatric Care	☐	☐
Arthritis / Rheumatism	☐	☐	Osteoporosis	☐	☐	Epilepsy or Seizures	☐	☐
Artificial Joint (Hip,Knee, etc.)	☐	☐	Cancer / Tumors	☐	☐	Fainting or Dizzy Spells	☐	☐
Diet (Special/Restricted)	☐	☐	Radiation Therapy	☐	☐	Nervous/Anxiety	☐	☐
Ulcers	☐	☐	Chemotherapy	☐	☐	Depression	☐	☐
Tobacco	☐	☐	Alcohol	☐	☐	Recreational drugs	☐	☐

10. Do you have, or have you had, any disease, condition, or problem not listed? If yes, please describe: _____ ☐ ☐

Women:	Yes	No			Yes	No		Yes	No
11. Are you pregnant?	☐	☐	Weeks?	_____	Nursing?	☐	☐	Birth Control Pills?	☐	☐

I certify that I have read and understand this form and answered all questions to the best of my knowledge. If additional information is needed, Hathcoat Family Dental has permission to contact my health care provider. I will notify Hathcoat Family Dental of any changes in my health/medication(s). The above information is needed to provide safe dental care.

Patient/Guardian Signature: _____ Date: _____

RDH review: _____ DDS Review: _____ Date: _____

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Appointment Policy

Hathcoat Family Dental strives to respect you and your schedule by providing individualized, quality, on-time dental care. We reserve appointment time exclusively for you and, in return, ask that you reserve your time for us.

As a courtesy to you, we make every effort to remind you of your upcoming appointment. It is your responsibility to notify us in advance if you are unable to make your appointment. In order to best accommodate all of our patients, we require that you provide notice at least **2 business days** (Monday – Thursday, 8am-5pm) before your appointment for rescheduling. This allows us time to contact other patients in need of an appointment.

If you have any questions, our staff or doctor will be happy to help you.

Appointment Rescheduling

_____ (initial) Appointments rescheduled or cancelled with less than **2 business days** advance notice are considered missed appointments and will be subject to a missed appointment fee.

Missed Appointment

_____ (initial) If you miss a scheduled appointment without advance notice, a missed appointment fee will be billed to you. It is your responsibility to pay this fee prior to receiving any additional dental treatment.

Late Arrival

Arriving late impacts the care we can provide you and our other patients. We will do our best to accommodate your late arrival, however, we may need to reschedule your appointment for another time.

_____ (initial) Arriving more than **15 minutes** after your appointed time will be considered a missed appointment and will be subject to a missed appointment charge.

Missed Appointment Fees

_____ (initial)
Dental Cleaning - $75
Dental Treatment - $100 for each appointed hour

I _____(patient or guardian name) have read and understand the **Appointment Policy** of Hathcoat Family Dental and I agree to the terms of this policy. A copy of this agreement has been offered to me.

_____ Signature

_____ Date