FINANCIAL AGREEMENT

- I, _____, am financially responsible for this account. **(Please Print)**
- Preferred method of payment: **(Circle)**

  Check/Cash Mastercard Visa Discover American Express Care Credit
- I, the undersigned, hereby give consent to the agreed upon dental services, and the use of appropriate methods thereto, on behalf of my **child**,

  _____
- Finance charges of 1-1/2 % per month, $1.00 minimum, will be added to accounts over 30 days past due. It is also understood that the person financially responsible for these services is ultimately responsible for payment in full without regard to payments by any insurance carrier. Balances are due within 30 days from date of service unless prior arrangements have been made.
- The undersigned further agrees that in the event of default on payment for services, he and/or she shall pay all costs and collections, including reasonable attorney fees.
- **NO SHOW POLICY:** I understand that I will be charged a $50.00 fee for ANY failed or cancelled appointment without a 24 hour notice.

Signature _____Date_____

HIPAA AGREEMENT

Please be advised that this is your acknowledgement of Receipt of Notice of Privacy Practices. If you would like to review this policy, please ask the receptionist for a copy. A copy can also be found on our website, www.nhdentalpartners.com.

Signature_____Date_____

EMPLOYMENT INFORMATION

- Employed By: _____
- Employer Phone Number:_____
- Dental Insurance Carrier: _____
- Group Number: _____

HIPAA Disclosure Form

Dr. Mark Horne

Patient Name:_____ Date:_____

Address:_____

Phone No._____E-Mail Address:_____

May we leave messages? ___ Yes ___ No

I, the Patient, hereby authorize the doctor listed above to release my personal health information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) ("Personal Health Information") via postal mail, telephone, text, fax, or email to the following family members:

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

I authorize the doctor to release my Personal Health Information for the purpose of scheduling appointments, continuing treatment, consultation, and billing.

I understand that I may revoke this authorization at any time by providing written notice of such revocation to NH Dental Partners. However, such revocation shall not apply to the extent that the doctor has already disclosed Personal Health Information in reliance of this authorization.

I understand that any Personal Health Information or other information released to the persons identified above may be subject to re-disclosure by such persons and may no longer be protected by applicable federal and state privacy laws.

I understand that I am not required to complete this authorization in order to receive treatment and have the right to refuse to complete this form.

Signature_____ Date_____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Acid Reflux
☐ ☐	Alcohol/Drug Abuse
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Artificial Joint (Hip/Knee)
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer
☐ ☐	Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Congestive Heart Failure
☐ ☐	Dementia
☐ ☐	Developmental Disorder/Autism
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Disabilities
☐ ☐	Emphysema
☐ ☐	Epilepsy

Y N	Conditions
☐ ☐	Epilepsy/Seizures
☐ ☐	Fainting Spells
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS
☐ ☐	Hearing Impaired
☐ ☐	Heart Attack
☐ ☐	Heart Murmur
☐ ☐	Hemophilia
☐ ☐	Hepatitis A/B/C
☐ ☐	High Blood Pressure
☐ ☐	Kidney Disease
☐ ☐	Liver Disease
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pre-Medicate
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems
☐ ☐	Stroke

Y N	Conditions
☐ ☐	Thyroid Disease
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Valve Replacement
☐ ☐	Venereal Disease
☐ ☐	

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)