PERSONAL HISTORY

(all information will be held in strict confidence)

Patient's Name_________________________ M or F Today's Date__________________________

Age______ Birthdate __________ Married Single Divorced Widow Spouse's Name ________________________

Home Address _________________________________ City____________________ State _____ Zip Code_______________

Phone: Cell ____________________ Home: __________________ Email: ____

Responsible Party Name (if under 18) __________________________Relationship ______________ Social # ________________

Address if different from above______________________________ Phone: Cell____________________ Home_____________

Father's Name ________________________Birthdate ___________Mother's Name____________________ Birthdate ____________

Responsible Party's Employer: Name, Street, City and Zip Code ____

Work #____________________

Nearest Relative not living with you _________________________Relation ______________ Phone #_______________

INSURANCE INFORMATION

PRIMARY Insurance Company Name _____________________________________ ID# or SS#_______________________________

Address: Street, City and Zip Code____ Phone # ____________________

Subscriber Name _________________________ Birthdate ____________Relationship to patient: ____________Group # _________

SECONDARY Insurance Company Name ____________________________ ID # or SS# _________________________________

Subscriber Name ___________________ Birthdate _______________ Relationship to patient:______________Group#____________

If accident, give date of details _____________________________________

Medical- Dental History

Referred by (circle) Dentist / Insurance / Friend / Online

Physician ______________________________________

Have you had a physical in the last 6 months? _____________

Prefer Pharmacy ___________________________________

Are you under physicians care now? ____________________

For what? _____________________________________

What drugs or medications are you taking? ______________

____

What drugs, medicines or other things are you allergic to?

____

____

Any unusual reactions to types of drugs or anesthetics? ________

____

What major operations have you had? ____________________

____

Height______________ Weight _______________________

Have you ever been or on Osteoporosis meds? Yes No Do not know

Have you had radiation treatments? Yes No Do not know

Have you had prolonged bleeding? Yes No Do not know

Do you have a pace maker? Yes No Do not know

Do you wear contact lenses? Yes No Do not know

Women patients, are you pregnant? Yes No Do not know

Do you smoke or have smoked? Yes No Do not know

Are you currently on weight loss shot? Yes No Do not know

Dentist ___________________ Phone __________________

Orthodontist ____________________Phone_____________

Have you had any of the following?

Diabetes	Yes	No	Do not know
Heart Disease	Yes	No	Do not know
Kidney Disease	Yes	No	Do not know
Liver Disease	Yes	No	Do not know
High Blood pressure	Yes	No	Do not know
Low Blood pressure	Yes	No	Do not know
Blood Diseases	Yes	No	Do not know
Emphysema	Yes	No	Do not know
Shortness of breath	Yes	No	Do not know
Chest Pain	Yes	No	Do not know
Epilepsy	Yes	No	Do not know
Tuberculosis	Yes	No	Do not know
Anemia	Yes	No	Do not know
Rheumatic Fever	Yes	No	Do not know
Hepatitis	Yes	No	Do not know
Asthma	Yes	No	Do not know
Fainting or dizziness	Yes	No	Do not know
Heart murmur	Yes	No	Do not know
Frequent cough	Yes	No	Do not know
Aids/ HIV	Yes	No	Do not know
Autism	Yes	No	Do not know

_______________________________________ ______________________

Signature of Patient (Parent or Guardian if patient is a minor) **Date**

Dustin J. Hopkin, D.D.S.

Oral & Maxillo-Facial Surgery

1377 East 3900 South Suite #104 SLC UT, 84124 Phone: 801-277-3942; Fax: 801-277-4505

Financial Policy and Agreement

Thank you for choosing Dr. Hopkin for your oral surgery needs. This office is committed to providing the highest quality oral surgery care. The following is an explanation of our Financial Policy and Agreement which we ask you to read and sign prior to any evaluation or treatment. **All** patients need to complete the information and insurance form before seeing Dr. Hopkin.

1. Each patient is responsible for his/her own bill. We charge FOR ALL office visits medical and dental related.

2. Payment of all insurance co-payments and deductibles is required at the time service is rendered. Most insurance companies will not pay the entire amount charged by Dr. Hopkin. You are still responsible for paying off the remaining balance. Without **WRITTEN** pre-authorization from your insurance company stating the amount they will pay; we must have a down payment on the day of service. All financial arrangements must be made prior to the services being rendered.

3. Patients who have no insurance are required to pay in full for services rendered at each visit. We accept cash, checks and credit cards.

4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our patients, we will be happy to process your insurance form for you, even though it means taking extra time and work for the office staff. To facilitate claims processing, you must provide all insurance policy information and changes to our office. However, you are still responsible to keep your account current whether you have insurance or not. **You are responsible for your account to us,** and your insurance is responsible to you. We will send one form initially to your insurance company. You will receive a monthly statement from our office on the remaining balance. If your insurance company has not paid your account in full within 60 days, the outstanding balance must be paid by you.
If there are problems with your insurance company, that problem should be solved by you and the company, not our office.

5. After 60 days, the patient and/or responsible party agrees to pay interest and/or services charges on any unpaid balance on the account. These charges will be applied monthly and will be the greater of $2.00 or 1.5% monthly (18% per annum).

6. If collection becomes necessary by suit or otherwise, the undersigned agrees to pay all costs of collection, including attorney fees, court costs, filing fees, and a collection fee of 40%, that may be assessed to our office by any collection agency retained to pursue this matter.

7. A $25.00 fee will be charged on all returned checks.

8. Patients that do not make their scheduled appointments without calling prior will be charged a $100 no-show fee.

9. Signing this form also gives express consent for our office to contact you, the patient and/or responsible party, through text messaging.

Usual and Customary Fees

Dr. Hopkin's rates for medical services reflect the usual and customary rates in the Salt Lake City area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for service.

Authorization to Release Information

I hereby authorize Dr. Hopkin to release all information concerning my medical treatment to my insurance carriers or referring physicians (if any).

Authorization to Pay Benefits

I have read and understood the above and I further authorize and direct said agency, attorney, or insurance company to pay, for the proceeds of benefits of any recovery or insurance payments in my case, to Dr. Dustin J. Hopkin for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying Dr. Hopkin when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

____ ____________

Signature of patient or responsible party Date

Dustin J. Hopkin, DDS

1377 East 3900 South Ste 104 Salt Lake City, Utah 84124 PH: 801-277-3942 FAX:801-277-4505

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (Including direct or indirect treatment by other health care providers involved in my treatment)
- Obtaining payment from third-party payers (e.g., my insurance company).
- The day-to-day healthcare operations of the practice.

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 you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and 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 such restrictions. I understand I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: ___/___/_____

Patient Name: ______________________________

Signature: ______________________________

Relationship to patient (If underage of 18) ____________________

RELEASE

I am giving permission for Dr. Hopkin's office to speak with the person I have listed below. I understand I can change this consent in writing at any time.

Name/ Relationship____

Name/ Relationship____

Name/ Relationship____

Signature of patient:

____

PHOTO RELEASE

I, __________________ grant permission and give my consent to Hopkin Oral Surgery for the use of the following photograph(s) or electronic media images as identified in our office.

Releasor's Signature ___________________________________ Date _________________________________