817-477-4441

mansfieldsnoreandsleepsolutions.com

1830 EAST BROAD STREET, SUITE 100

MANSFIELD TEXAS 76063

Date _____

1. **Patient's Name** _____ **Preferred to be called** _____
Last First Middle

2. Address _____ Driver's License # _____
Street City State Zip

3. Home Phone _____ Birthdate _____ Age _____ Social Security # _____

4. E-Mail Address _____ Cell # _____

5. Employer _____

6. Occupation _____

7. Work Phone _____

8. **Person Responsible for Payment** _____
Last First Middle

9. Address _____
Street City State Zip

10. Relationship to Patient _____

11. Social Security # _____

12. Birthdate _____

13. Driver's License # _____

14. Home Phone _____

15. Employer _____

16. Work Phone _____

(if minor, list parent's names:)

Father _____
First Last

Mother _____
First Last

MEDICAL INSURANCE INFORMATION TO ASSIST YOU IN FILING ELECTRONICALLY

17. Insured's Name (employee) _____

18. Insured's Birthdate _____

19. Insured's Address (if different from above) _____

20. Insured's Social Security # _____

21. Insured's Employer _____

22. Insurance Co. Name _____ Group Name _____

23. Insurance Address _____

EMERGENCY INFORMATION

24. Local Friend or Relative not living with you _____

25. Complete Address _____

26. Phone No. _____

GETTING TO KNOW YOU

27. Why did you select our office? _____

28. Whom may we thank for referring you? _____

29. Is another member of your family or relative a patient in our practice? _____

30. When was your last medical visit? _____

31. When was the last time you had complete dental X-rays taken? _____ Dentist: _____

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the care of the patient above. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or her staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY _____ RELATIONSHIP _____ DATE _____

Mansfield Snore & Sleep Solutions

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ❑ YES ❑ NO
   If yes, for what reason?_____
2. Are you having medical problems at this time? ❑ YES ❑ NO
3. Do your gums bleed at any time? ❑ YES ❑ NO
4. Do you feel very nervous about having medical treatment? ❑ YES ❑ NO
5. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ❑ YES ❑ NO
   If yes, please list. _____
6. Have you ever had excessive bleeding requiring special treatment? ❑ YES ❑ NO
7. Check any of the following which you have had or have at present:

❑ Heart disease or Attack	❑ Diabetes	❑ Arthritis
❑ Artificial Heart Valve	❑ Kidney Trouble	❑ Cortisone Medication or Injections
❑ Heart pacemaker	❑ Asthma	❑ Ulcers (Stomach)
❑ Heart surgery	❑ Shortness of Breath	❑ Glaucoma
❑ Heart murmur/mitral Valve	❑ Liver Disease	❑ Hemophilia
❑ High blood Pressure	❑ Hepatitis B (Serum)	❑ Bruise Easily
❑ Rheumatic Fever	❑ Hepatitis A	❑ Epilepsy or Seizures
❑ Scarlet Fever	❑ Artificial Joint	❑ Drug Addiction
❑ Cancer or tumor	❑ HIV Positive(AIDS)	❑ Psychiatric Treatment
❑ Chemotherapy (Cancer, Leukemia)	❑ Tuberculosis (TB)	❑ Nervousness
❑ Stroke	❑ Thyroid Disease	❑ Cold Sores or Fever Blisters

- Do you have any disease, condition or problem not listed? If so, please list ❑ YES ❑ NO

_____

_____

_____

8. List all medications you are taking at this time._____

_____

_____

9. Are you a smoker? ❑ YES ❑ NO
10. Do you use or have you ever used recreational drugs? ❑ YES ❑ NO
11. Do you ever wake up from sleep short of breath? Do you snore? ❑ YES ❑ NO
12. Do you clench or grind your teeth? ❑ YES ❑ NO
13. Do you have pain in your jaw joints or ringing in your ears? ❑ YES ❑ NO
14. Women: Are you pregnant ❑ YES ❑ NO If yes, what month are you due?_____

- How do you feel about getting and maintaining a healthy mouth?_____

_____

- How do you feel about the appearance of your teeth?_____

_____

- If you could change anything about your smile, what would you change? _____

_____

Signature:_____ Date:_____

mansfieldsnoreandsleepsolutions.com

FINANCIAL ARRANGEMENTS

We appreciate your confidence in us to provide you with care. These are the

following financial options we provide.

1) Payment in full at the beginning of complete treatment plan over $1500 allows us to extend the following discounts: 7% cash or check, 4% credit card.
2) We can provide you a choice of several extended payment options with comfortable monthly payments for 6-24 months; several are interest free for 6-12.

In our effort to keep cost down and be environmentally conscious, we have eliminated billing and sending monthly statements. If you have medical insurance, your options are:

1) Payment in full at the time of service, we will file your insurance and you will receive direct reimbursement to you from your Insurance Company. (Usually in less than 2 weeks)
2) We will take Insurance assignment if:
    1. You pay your estimated portion at the time of service
    2. You leave a Credit Card number on file for any unpaid portion. We will charge the Credit Card any unpaid balance after your Insurance has paid or in 30 days. If the amount is over $150 we will call you before processing your card.

It has always been our philosophy to be up front about our fees. Your insurance policy is a contract between you and the insurance company. Dr. Hamm is not contracted with any insurance company. We will be happy to file your insurance and give you an estimate of your insurance expenses. Our relationship is with you, not your insurance company. Your insurance carrier may not approve or reimburse your services due to usual and customary rates, benefit exclusions, coverage limits, and lack of authorization or medical necessity. By understanding your needs and listening to your circumstances, we will do our best to give you financing options, or phase your treatment as needed.

If you have any questions, please feel free to discuss them with us. It is our goal to provide you with the highest quality of care and service.

Signature_____Date_____

817-477-4441
mansfieldsnoreandsleepsolutions.com

1830 EAST BROAD STREET, SUITE 100
MANSFIELD TEXAS 76063

Health Insurance Portability and Accountability Act Consent Form

Due to the health insurance portability and accountability act, our office is now required to give all patients the ability to obtain a copy of our privacy policy. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office reception room for patients to review. Please sign this as your acknowledgement that this office is following HIPPA policy.

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have a right to read our Notice of Privacy Practices before you decide whether to sign this consent. You will have the right to evoke this consent at any time by giving us written notice of your revocation by certified mail.

Please initial the following statements:

_____ Protected information may be disclosed or used for treatment, payment, or healthcare operations.
_____ The practice has a Notice of Privacy Practices & that I have the opportunity to review that notice.
_____ The practice reserves the right to change the Notice of Privacy Policies.
_____ Patients have the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
_____ The patient may revoke this consent in writing at any time & all future disclosures will then cease.
_____ The practice may condition treatment based on the execution of this consent.

In order to insure the accuracy of your proctected health information, it is our office policy to update this form annually.

I authorize Dr. Hamm to release my medical or insurance information as necessary to process my medical claims and coordinate or manage my medical care.

In the event of a family member or caregiver attends my medical visit and is in the exam room at the time of my evaluation or treatment, I give Dr. Hamm and her staff members my permission to discuss freely, my condition, treatment, or diagnosis with that person. **Yes / No**

Home Phone: (_____) _____ May we leave a message? **Yes / No**

Work Phone: (_____) _____ May we leave a message? **Yes / No**

Cell Phone: (_____) _____ May we leave a message? **Yes / No**

Email Address: _____ May we leave a message? **Yes / No**

May we call your name out loud in our lobby? **Yes / No**

With whom may we discuss financial issues relating to treatment & diagnosis? _____

Printed Name of Patient: _____

Date: _____ Signature: _____

Relationship to patient: _____