Doctor Christopher
HOOPER
General & Cosmetic Dentistry

840 First Colonial Road • Suite 103 • Virginia Beach, Virginia 23451 • (757) 417-7300

CONFIDENTIAL

PATIENT INFORMATION

Date _____

Name _____ Nickname _____ Birth Date _____

Sex: M F Marital Status: (Please circle one) Single Married Separated Divorced Widowed

Address _____ City _____ State _____ Zip _____

Email _____ Phone (home) _____ (cell) _____ (work) _____

Employer _____ Work Phone _____

SSN _____ Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone: _____

Are any of your family members patients here? Yes No If so, who? _____

Person responsible for payment of account (person's name to appear on billing statement) Self Spouse Parent or Guardian Other

If you circled "Self," please skip second section and go on to the third section

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name _____ Birth Date _____ M F

Home Address (If different from above) _____ Phone _____

Employer _____ Social Security Number _____

Business Address _____ Phone _____

PATIENT'S SPOUSE (OR PARENT)

Name of Spouse or Parent or Guardian _____ M F DOB _____

Employer _____ Social Security Number _____

Business Address _____ Phone _____

INSURANCE INFORMATION -

Please allow us to copy your Insurance Card and a Photo ID. Your insurance coverage, if any, is an agreement between you and your carrier. As a courtesy we will be happy to file your insurance for you. You are responsible for all fees at the time of service.

PLEASE CONTINUE WITH BACK OF FORM

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MEDICAL HISTORY

Name of your physician _____ Date of last physical _____

Physician's address _____ Phone _____

Are you taking any medication now? Yes No Please list _____

Are you pregnant? Yes No Do you take birth control? Yes No

Do you have any of the following?

	Yes	No		Yes	No		Yes	No
AIDS	❑	❑	Heart Murmur	❑	❑	Rheumatic Fever	❑	❑
Anemia	❑	❑	Heart Trouble	❑	❑	Sinus Condition	❑	❑
Arthritis	❑	❑	Hepatitis	❑	❑	Skin Disease	❑	❑
Asthma	❑	❑	Herpes	❑	❑	Stroke	❑	❑
Cancer	❑	❑	High Blood Pressure	❑	❑	Thyroid Disease	❑	❑
Diabetes	❑	❑	HIV	❑	❑	Tuberculosis	❑	❑
Emphysema	❑	❑	Kidney Disease	❑	❑	Ulcer	❑	❑
Epilepsy	❑	❑	Leukemia	❑	❑	Psychological Disorder	❑	❑
Pacemaker	❑	❑	Low Blood Pressure	❑	❑	Depression	❑	❑
Frequent Headaches	❑	❑	Joint Replacement	❑	❑	Anxiety	❑	❑
Hearing Loss	❑	❑	Prolonged Bleeding	❑	❑	Any disability	❑	❑

Are you allergic or have had a reaction to:	Yes	No
Local anesthetics	❑	❑
Penicillin or other antibiotics	❑	❑
Sulfa drugs	❑	❑
Barbiturates, sedatives or sleeping pills	❑	❑
Aspirin	❑	❑
Wine or Foods	❑	❑
Codeine or other narcotics	❑	❑
Other _____		

Additional information about your health that we should know: _____

Were you ever advised by your doctor to have antibiotics before any medical or dental treatment? Yes No

Have you ever had any serious trouble associated with any previous dental treatment? Yes No

If so, please explain: _____

DENTAL HISTORY

Yes No Bleeding gums?

Yes No Bad breath?

Yes No Sore areas in your mouth?

Yes No Pain in or near your ears?

Yes No Sensitivity to heat, cold or sweets?

Yes No Frequent headaches or tired jaws?

Yes No Do you use smokeless tobacco?

Yes No Do you smoke?

Yes No Have you ever been treated by a Periodontist? (Gum Specialist)

Yes No Have you ever been treated by an Orthodontist? (Braces)

Yes No Do you have a specific dental problem or pain?

Yes No Do you have TMJ?

Yes No Were Panoramic (Full mouth x-rays) taken within the last 3 years that we can obtain from your previous dentist?

Yes No Are you happy with your smile? If no, why not? _____

Date of last dental visit? _____

AUTHORIZATION

I (we) the undersigned authorize treatment by the doctor and supporting staff members.

I (we) consent to the release of information as may be necessary for insurance, dental, medical consult or collection.

I (we) understand there may be a minimum charge of $50.00 for broken appointments without 24 hours notice.

I (we) understand that my insurance will be files as a courtesy, but I am responsible for full payment of services.

I (we) accept full responsibility for payment of all charges incurred as well as attorneys fees of 33.3% and any other related costs of collection should actions become necessary.

There will be a $10.00 monthly rebilling fee added to any account that is delinquent, plus interest of 18%.

I (we) certify all the above to be filed out correctly and truthfully.

PAYMENT OF PERSONAL FEES Please check method of payment best for you: ❑Cash ❑Check ❑Mastercard / Visa

Patient's Signature _____ Date _____

Parent or Guardian's Signature _____ Date _____

CHRISTOPHER A. HOOPER, DDS & ASSOCIATES, LTD.

HIPAA FORM

This office realizes the importance of the confidentiality of each of our patient's personal information and medical history. We keep your information private, and the entire staff is aware of such confidentiality requirements.

We will only release medical information that is necessary for insurance billing or essential for communication with other health care providers. In order to maintain the highest level of patient care AND assure your privacy, you are asked to sign below to authorize sharing of medical information with other healthcare providers involved in your care.

_____
name printed

_____ _____
signature date

CHRISTOPHER A. HOOPER, DDS & ASSOCIATES, LTD.

Patients With Dental Insurance

For Patients having Crowns, Bridges and other major treatment, unfortunately some insurance companies have begun to deny treatments that should be covered benefits. As a courtesy to our patients we do call and use on-line means to retrieve benefits from Insurance companies. Insurance coverage for treatment even, when pre-authorization is received, is not a Guarantee insurance will pay. Therefore, insurance co-payments are only an estimate of the cost for the patient. Please discuss any concerns you have before treatment. Treatment cost will ultimately be the responsibility of the patient. Thank you for your understanding that due to insurance lower reimbursements and rising insurance write-offs this allows us to continue to treat and care for our patients with the highest quality of care. By signing below, you agree to cover all fees, even if they are denied by your insurance company.

PATIENT NAME: _____ **DATE:** _____