JEFFREY N. HAMLIN, D.M.D., P.C.
ORAL, MAXILLOFACIAL AND IMPLANT SURGERY

1850 WHITES ROAD, SUITE 1 • KALAMAZOO, MI 49008
PHONE: (269) 385-2101 • FAX: (269) 385-6908
www.hamlinoralsurgery.com

Dear New Patient:

Thank you for choosing to make an appointment with Dr. Hamlin. Your upcoming appointment has a special meaning for us, and we hope that we can make your experience a satisfying one.

Enclosed you will find the necessary paperwork that can be completed and brought with you to your appointment. Along with this paperwork, please bring the referral form your dentist gave you indicating what your treatment entails. Also, if you have x-rays that are under a year old, please request your dentist to forward those to our office, or you can bring them with you the day of your appointment. Please be advised that we will try our best to use the x-rays you have already had taken, but in some cases, it is necessary that we take our own for surgical purposes. Please remember that co-payments are due on the day of service; also, bring your dental insurance cards to ensure correct billing information.

For those patients who are having their surgery with I.V. sedation (going to "sleep"), please remember **not to eat or drink anything 6 hours prior to surgery. You will also need to wear a short sleeved shirt for the placement of the I.V. and monitors, and you will also need a responsible driver for your ride home.**

For those patients who are having local anesthetic ("numbing shots") with or without Nitrous Oxide ("Laughing gas"), there are no restrictions, and you can eat, drink and drive yourself home.

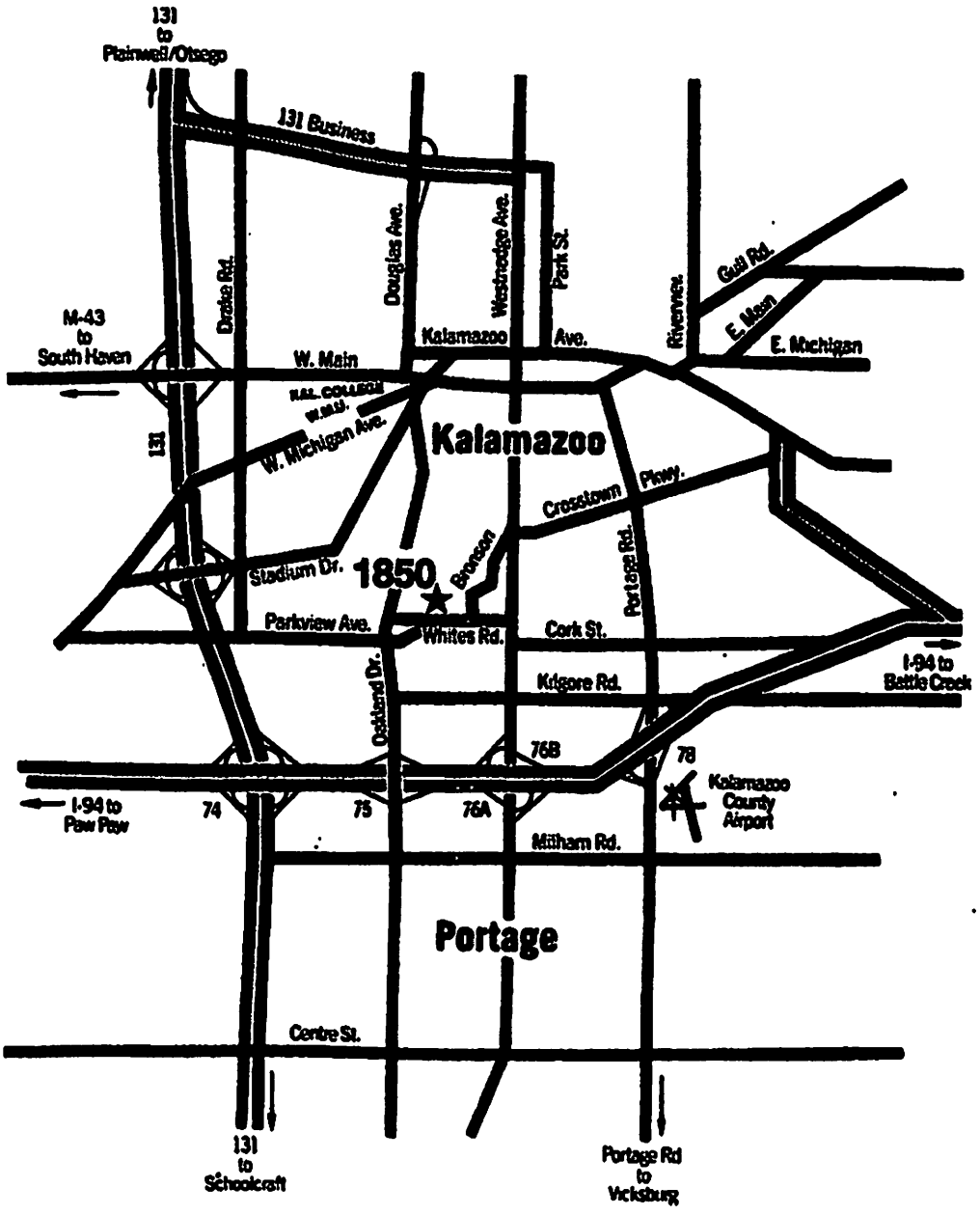
Please arrive fifteen minutes early to your appointment time, and thirty minutes early if you need to complete the paperwork at our office. Feel free to visit our website to review post-operative instructions or to obtain additional information. If you have any further questions or concerns, please do not hesitate to contact our office.

Once again, thank you for choosing our practice. We look forward to meeting you!

Kindest Regards,

Dr. Hamlin and Staff

Fellow, American Association of Oral and Maxillofacial Surgeons
Diplomate of the American Board of Oral and Maxillofacial Surgery


131
to
Plainwell/Otsego
131 Business
Douglas Ave.
Westnedge Ave.
Park St.
Riverview
Gull Rd.
E. Main
E. Michigan
Drake Rd.
M-43
to
South Haven
W. Main
Kalamazoo
Ave.
RAIL COMMON
W.M.U.
W. Michigan Ave.
131
Kalamazoo
Crosstown
Pkwy.
Stadium Dr.
1850
Bronson
Portage Rd.
Parkview Ave.
Whites Rd.
Cork St.
I-94 to
Battle Creek
Oakland Dr.
Kilgore Rd.
76B
78
Kalamazoo
County
Airport
I-94 to
Paw Paw
74
75
76A
Milham Rd.
Portage
Centre St.
131
to
Schoolcraft
Portage Rd
to
Vicksburg

HEALTH HISTORY

Patient's Name **Date of Birth** **Date**

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - R. Sinus or Nasal problems? ..... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - T. Have you been told by your physician to take an antibiotic premedication due to a specific health condition prior to dental care? ..... Y N
7. **ARE YOU USING ANY OF THE FOLLOWING?**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? ..... Y N
   - J. Have you ever been advised <u>not</u> to take a medication? ..... Y N
   - K. **Please list any and all medications taken**, including *prescription medications, diet drugs, over-the-counter medications, vitamins, illicit drugs, Marijuana, etc.* **<u>We need to know what you're taking for your health and safety with anesthesia:</u>**

     _____

     _____

     _____

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber products? ..... Y N
   - G. Metal of any kind? ..... Y N
   - H. Chemicals or jewelry (rash or sensitivity)? ..... Y N
   - I. Food products? ..... Y N
   - J. Other allergies or reactions? Please list ..... Y N

     _____

     _____

9. Do you smoke or chew Tobacco or Marijuana? ..... Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
14. Do you wish to talk to the doctor privately about anything? ..... Y N
15. Have you ever had a bone density scan? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or <u>is there any chance</u> you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. <u>If you are using Oral Contraceptives</u>, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist Dr. Hamlin in providing the best care possible. I will not hold Dr. Hamlin or his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature of Person Completing Health History _____ Relationship to Patient _____

Jeffrey N. Hamlin, D.M.D., P.C.
Oral, Maxillofacial and Implant Surgery

Patient Information

Name: _____ Birthdate: _____ Age: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Sex: _____Male _____Female

Status: _____Single _____Married _____Widowed _____Divorced _____Seperated

Patient's Employer/ Occupation: _____
If the patient is a student/ name of school

Social Security #: _____

Referring Dentist's Name: _____

Orthodontist's Name: _____

Physician's Name: _____ Date of last visit: _____

In Case of Emergency Contact Information:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Dental Insurance Information:

Primary Insurance:

Policy Holder's Name: _____

Relationship to Patient: _____ Birthdate: _____

Soc. Sec. #: _____ ID #: _____

Group #: _____

Employer: _____

Insurance Co. Name: _____

Secondary Insurance:

Policy Holder's Name: _____

Relationship to Patient: _____ Birthdate: _____

Soc. Sec. #: _____ ID #: _____

Group #: _____

Employer: _____

Insurance Co. Name: _____

Print Name Signature Date

Dr. Jeffrey N. Hamlin

Office Financial Policy

Dr. Hamlin is here to assist you in all aspects of your dental care, including financial arrangements. This office's basic policy is that payment is made at the time service is rendered.

I understand that dental services furnished to me are charged directly to me (my account) and that I am personally responsible for payment of all dental services.

If I carry insurance, I understand that this office will help prepare my insurance forms as a courtesy to assist in collecting from insurance companies and will credit such collections to my account. However, this office cannot render services on the assumption that all charges will be paid by an insurance company. This office tries its best to estimate the amount your insurance company will cover, but we **do not guarantee** the amount of coverage until actual payment is received. The amount of the deductible, as well as co-payments, are payable at the time of service.

I understand that this office will bill me for the remaining portion of my balance, if any, once all insurance claims and payments have been received. If I do not make payments after 2 months of billing, I understand that I **will** be sent to collections. Furthermore, I agree to pay a $35.00 service charge on all returned checks and a $50.00 cancellation fee if appointments are not cancelled 24 hours prior to the appointment date.

Patient's Signature _____ Date _____

Please Print Patient's First and Last Name _____

Signature of financially responsible party if other than patient _____ Relationship to Patient _____

Financially responsible party's Social Security Number _____ Date of Birth _____

Jeffrey N. Hamlin, D.M.D., P.C.
Oral, Maxillofacial and Implant Surgery
1850 Whites Road, Ste. 1
Kalamazoo, MI 49008
269.385.2101

HIPAA Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

I am able to obtain this practice's Notice of Privacy Practices written in plain language at their office or on their website, *hamlinoralsurgery.com*. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

- May we leave a message on your voicemail at home or on your cell phone? Yes No
- May we phone, email or send a text message to you to confirm appointments? Yes No
  - Email address:_____
- May we discuss your medical condition with any member of your family? Yes No
  - If yes, please name the allowed members and their relationship to you:

    _____
    _____
    _____
    _____

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____