

Hall FAMILY DENTISTRY

ROBERT B. HALL, JR., D.D.S.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Home Phone (____) _____ Cell Phone (____) _____

Name _____ Do you accept text messages? _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ Soc. Sec. # _____

State _____ Zip _____ Driver's License # _____

Sex M F Age _____ Birthdate _____ Married Widowed Single Minor

Name of Pharmacy _____ Separated Divorced Partnered for ____ years

Patient Employer/School _____ Occupation _____

Patient Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Responsible Party Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company & Address _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependants covered under this plan _____

AUTHORIZATION (PLEASE READ ENTIRE PARAGRAPH AND SIGN BELOW)

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I certify that I, and/or my dependant(s), have dental insurance coverage with _____ and assign directly to Dr. Hall all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Dr. Hall may use my health care information with the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

If I do not pay the entire balance within 30 days from the date of service, a late charge of 1.5% will be assessed each month. I realize that failure to keep this account current may result in inability to receive additional dental services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees (35%) incurred in attempt to collect on this account. There will be a \$25.00 returned check fee for all returned checks. There will be a \$50.00 fee for broken appointments or cancelled appointments without 24 hour notice.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growth in your mouth |

How often do you floss? _____ How often do you brush? _____

Frequency of sugar exposures / day (sugary drinks, soda, candy, etc.): _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Are you under a Physician's care now? Yes No N/A _____

Have you ever been hospitalized or had a major operation? Yes No N/A _____

Have you ever had a serious head or neck injury? Yes No N/A _____

Are you taking any medications, pills, or drugs? Yes No N/A _____

Do you take or have taken Bisphosphonates (aredia, fosamax)? Yes No N/A _____

Do you use tobacco? Yes No N/A _____

Are you on a special diet? Yes No N/A _____

Do you use controlled substances? Yes No N/A _____

Women: Are you Pregnant: ___ trimester Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? _____

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have, or have you had, any of the following? _____

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | |

Have you ever had any serious illness not listed above? Yes No N/A

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I acknowledge that I received a copy of the HIPPA Privacy notice.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient