



PATIENT REGISTRATION

Preferred Name: _____
First Name: _____ MI _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell: _____ Email: _____
Birth Date: _____ Age: _____ Sex: Male Female
Marital Status: Married Single Divorced Widowed
Social Security #: _____ Driver's License: _____
Employer: _____ Work Phone: _____
Emergency Contact: _____ Phone: _____
Whom may we thank for referring you to our office: _____

Responsible Party (if different from above): Preferred Name: _____
First Name: _____ MI _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell: _____ Email: _____
Birth Date: _____ Age: _____ Sex: Male Female

Primary Dental Benefits Provider:

Subscriber Name: _____
Subscriber DOB: _____
Relationship to Patient: _____
Employer Name: _____
Ins. Company: _____
Member ID: _____
Group ID: _____

Secondary Dental Benefits Provider:

Subscriber Name: _____
Subscriber DOB: _____
Relationship to Patient: _____
Employer Name: _____
Ins. Company: _____
Member ID: _____
Group ID: _____

***As a courtesy to our patients, we offer 3 ways to confirm an upcoming appointment. Which would you prefer:** Email: _____
 Text Message: _____
 Phone: _____

Notices:

As a service to our patients, we will bill your insurance company for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid in full. We at no time guarantee what your dental benefits will or will not cover.

(SIGNATURE)

(DATE)

Dental History

Patient Name: _____ Date of Birth: _____

Reason for your appointment today: _____

Have you had regular dental care in the past: YES NO (circle one)

If yes, when and where: _____

If yes, were x-rays taken: _____

How often do you brush: _____ How often do you floss: _____

Please answer the following questions:

(circle one)

Do your gums bleed while brushing or flossing? YES NO

Do you have any loose or missing teeth? YES NO

Do you have any sore or sensitive teeth? YES NO

Do you currently wear a denture or partial? YES NO

Are your gums red, swollen or tender? YES NO

Do you currently have any UN-COMPLETED dental work diagnosed by your previous dentist? **If yes, please explain:**

Did you go through orthodontic treatment in the past? YES NO

Do you clench or grind your teeth? YES NO

If yes, do you wear a night guard? YES NO

Have you ever NOT scheduled dental treatment due to fear? YES NO

Are you satisfied with the appearance of your smile? YES NO

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

(signature)

(date)



Financial Agreement

Thank you choosing Hall Cosmetic & Family Dentistry for you're your dental care. We want to establish a long and pleasant relationship with you. Just as we are committed to providing excellent dental care, we also strive to make it affordable to you.

Please read and sign that you understand each of the following policies:

1. **PLEASE UNDERSTAND** that we file dental insurance as a courtesy to our patients. Dr. Hall is currently in network with the following dental insurance providers:

- *BLUE CROSS AND BLUE SHIELD OF ALABAMA
- *CIGNA
- *AETNA
- *SOUTHLAND

Most dental plans only cover a portion of the dental fee, which means you will be responsible for your deductible and the estimated portion at the time services are rendered. We can only **ESTIMATE** your coverage in good faith. **We at no time guarantee what your insurance will or will not cover.** As a service to our patients, we will bill your insurance company for services and allow them 45 days to render payment. After 60 days, you (the policyholder) will be responsible for the entire balance, paid in full. If you have any questions, please feel free to contact our office.

2. Our office gladly accepts **Cash, Check, American Express, Visa, Mastercard and Discover**. We do not currently offer "in house" financing options, however, we have partnered with **Care Credit** (subject to credit approval). Care Credit offers several short term no-interest payment plans. You can apply for Care Credit in our office with our assistance, over the phone at 1-800-365-8295 or online at www.carecredit.com.
3. **TREATMENT ESTIMATES** are presented to you on the day that the treatment is proposed. Please remember that this is only an **ESTIMATE**. If you have an questions regarding treatment of the estimate given for services, you may contact our office at anytime.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY INSURANCE. I AGREE TO SUPPLY ALL NECESSARY INSURANCE INFORMATION TO HALL COSMETIC & FAMILY DENTISTRY.

SIGNATURE

DATE

JOSHUA B. HALL, D.M.D.
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

“You May Refuse to Sign This Acknowledgement”

I, _____, have received a copy of this office’s Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign**
- Communications barriers prohibited obtaining the acknowledgement**
- An emergency situation prevented us from obtaining acknowledgement**
- Other (Please Specify)**



APPOINTMENT AGREEMENT

Dr. Hall reserves an appointment time specific for you and your dental needs. We make every effort to value your time and stay on schedule, so we respectfully ask our patients to be prompt and keep their appointments. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care. Our appointment policy is as follows:

COURTESY CONFIRMATION: We will attempt to contact you either by phone, text or email 48 hours prior to your scheduled appointment. This is to verify with you the day and time reserved for your dental needs.

_____ **INITIAL**

48 HOURS NOTICE: If you must cancel or reschedule your appointment, please call our office at least 48 hours in advance. A 48 hour notice is required to cancel or change an appointment. A \$50.00 broken appointment fee may be charged to your account if the appointment is missed, cancelled or rescheduled without 48 hour notice. After 2 appointments in which the required 48 hour notice is not given, a \$50.00 deposit may be required to schedule any further appointments with our office.

Exceptions to this policy will be determined only on an individual basis, according to the circumstances. We fully understand that unexpected emergencies can occur. Please contact our office immediately and we will do our best to accommodate your situation. _____ **INITIAL**

DEPOSIT: A deposit will be required for any restorative or cosmetic work in order to reserve time with Dr. Hall to complete treatment. The amount of the deposit will be at least **50%** of the proposed treatment.

_____ **INITIAL**

***By signing this appointment agreement, you understand that your appointment time is a reservation with our office. Any appointment cancelled or rescheduled without 48 hour notice, may result in a \$50.00 fee being applied to your account.

(SIGNATURE)

(DATE)



CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Hall Cosmetic & Family Dentistry, to take photographs, and/or videos of my mouth, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education, social media outlets (Facebook and Instagram)

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Signature: _____

Date: _____

Eaglesoft Medical History(Copy)(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you require pre-medication prior to dental appointments? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics
 Augmentin

Do you use controlled substances? Yes No If yes

Other? If yes

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed Yes No If yes

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.

Signature of Patient, Parent or Guardian:

X Date: _____



HALL

COSMETIC & FAMILY
DENTISTRY

6930 Cahaba Valley Road, Suite 100
Birmingham, AL 35242
205-991-7840
www.birminghamdmd.com

Authorization to Release Dental Information

Patient Name: _____ Date of Birth: _____

I, _____ give my permission for Hall Cosmetic & Family Dentistry to release/discuss my personal dental information to the following family members, caretaker or personal representative.

Name: _____

Relationship to patient: _____

Telephone Number: _____

Name: _____

Relationship to patient: _____

Telephone Number: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

