HALL
COSMETIC & FAMILY DENTISTRY

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:** _____	YES	NO
Did you go through orthodontic treatment in the past?	YES	NO
Do you clench or grind your teeth? **If yes, do you wear a night guard?** YES NO	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)

HALL
COSMETIC & FAMILY
DENTISTRY

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: _____

HALL COSMETIC & FAMILY DENTISTRY

Time 2:32 PM

Date 7/20/2017

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