



NEW PATIENT INFORMATION

Personal Information

Mr./Mrs./Ms./Miss (Last) _____ (First) _____ (MI) _____

What name shall we call you? _____ Date of Birth _____ Sex _____

Home address _____

City _____ State _____ Zip _____

E-mail address _____

Home # _____ Cell # _____

Employer _____ Occupation _____

Spouse Name _____ Children(s) names _____

Parent /guardian name if minor _____

Emergency contact _____ Relation _____ Telephone _____

Who may we thank for referring you? _____

Are you a full-time college student? Name of school and city: _____

Insurance Information

Name of Insurance _____ Subscribers Name _____

DOB _____ ID # _____ Group # _____

Phone# of Insurance _____ Employer Name _____

HEALTH/DENTAL INFORMATION

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? CIRCLE YES OR NO

LOW BLOOD SUGAR	Y N	HIV POSITIVE	Y N	ARE YOU PREGNANT	Y N
DIABETES	Y N	AIDS	Y N	RHEUMATIC FEVER	Y N
HAY FEVER, ALLERGIES	Y N	SPINAL FUSION	Y N	MITRAL VALVE PROLAPSE	Y N
ASTHMA	Y N	ARTIFICIAL JOINTS	Y N	HEART DISEASE	Y N
CIRCULATORY PROBLEM	Y N	OSTEOPOROSIS	Y N	HEART ATTACK	Y N
HEPATITIS A, B, C	Y N	SINUS PROBLEMS	Y N	HEART PACE MAKER	Y N
JAUNDICE	Y N	ANEMIA	Y N	HEART SURGERY	Y N
LUNG PROBLEMS	Y N	BLOOD DISORDER	Y N	STROKE	Y N
TUBERCULOSIS	Y N	EXCESSIVE BLEEDING	Y N	HIGH BLOOD PRESSURE	Y N
EPILEPSY/SEIZURE	Y N	FAINTING/ BLACKOUTS	Y N	LOW BLOOD PRESSURE	Y N
BLOOD TRANSFUSION	Y N	NERVOUS DISORDER	Y N	HEART VALVE REPLACEMENT	Y N
FACIAL/HEAD INJURY	Y N	HEADACHES/MIGRAINES	Y N	SEVERE SPINAL STENOSIS	Y N
RADIATION	Y N	KIDNEY PROBLEMS	Y N	THYROID PROBLEMS	Y N
CHEMOTHERAPY	Y N	GLAUCOMA/EYE ISSUE	Y N	HIGH CHOLESTEROL	Y N
MALIGNANCIES	Y N	ULCERS	Y N		
CANCER	Y N	DIGESTIVE PROBLEMS	Y N		
LATEX ALLERGY	Y N	EATING DISORDERS	Y N		

DO YOU HAVE ANY OTHER DISEASES OR CONDITIONS NOT LISTED ABOVE? IF YES PLEASE LIST:

DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY

(ASPIRIN) (CODEINE) (ANESTHETICS) (XYLOCAINE) (NOVOCAINE) (LIDOCAINE) (SEDATIVES) (SULFA) (PENICILLIN) (ERYTHROMYCIN) OTHER:

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN OR A PRINTED COPY OF YOUR LIST: _____

NAME AND PHONE # OF PHYSICIAN: _____

HAVE YOU BEEN HOSPITALIZED IN THE LAST YEAR? IF YES, EXPLAIN _____

DO YOU CONSUME ALCOHOL OR USE TOBACCO? Y or N IN WHAT QUANTITIES? _____

HAVE YOU EVER BEEN TREATED BY A PERIODONTIST, ORTHODONTIST OR ENDODONTIST? Y N IF YES, EXPLAIN _____

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? Y or N

REASON FOR THIS DENTAL VISIT: _____

DATE OF YOUR LAST DENTAL CLEANING: _____ WAS YOUR LAST DENTAL CLEANING AT THIS OFFICE? Y OR N

HAVE YOU NOTICED ANY OF THE FOLLOWING?

DISCOMFORT IN FACE, HEAD, NECK, JAW	Y N	JAW CLICKING OR POPPING	Y N
LOOSE TEETH	Y N	SWELLING OR LUMPS IN MOUTH	Y N
FOOD CAUGHT BETWEEN TEETH	Y N	BLEEDING OR SORE GUMS	Y N
SENSITIVITY TO SWEETS, HOT OR COLD	Y N	RECURRING SORE IN OR AROUND MOUTH	Y N
TEETH TENDER TO CHEWING	Y N		

To avoid any misunderstanding concerning your dental insurance, we wish for our patients to know that all professional services rendered will be out of network and charged directly to the patient who is responsible for the payment of said services. We do not render service or treatment on the basis that the insurance company will pay our fees unless a pre-determination of benefits has been established in writing. However, we will file the necessary insurance forms for all treatment and services that have been completed. Payment is due when the service is rendered unless other arrangements have been made. If you must change a scheduled appointment, please inform the office within 2 business days of your scheduled appointment to avoid a charge to your account.

I hereby authorize Chase Hall, DMD to take radiographic X-rays, study models, photographs or any other diagnostic aid deemed necessary to make a thorough diagnosis for my dental care. I also authorize the doctor to prescribe necessary forms of medication, and to perform any treatment that may be indicated and agreed upon regarding my dental care.

I understand my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to provide and coordinate my treatment among consulting health/dental care providers who may be involved in that treatment directly and indirectly. I further authorize the release of any information regarding the diagnosis and records of treatment to my insurance company. The release of such information to the insurance company is solely for the purpose of facilitating the billing and reimbursement of treatment directly to the dentist for insurance benefits under which I am entitled. I understand the responsibility for payment of services rendered for myself and my family are due and payable at the time the services are performed.

I also give my consent to receive emails and text messages from Hall Family Dental Care regarding appointment reminders and other correspondence regarding my dental care.

Under the requirements for HIPAA we are not allowed to give your protected health information to anyone without your consent. If you wish to have a family member or someone close to you have access to your private health information, please indicate below.

You May Disclose My Information To The Following Do Not Disclose My Information To Anyone But Me

1. _____ Relationship to Patient: _____ Date: _____

2. _____ Relationship to Patient _____ Date: _____

MY SIGNATURE CONFIRMS THAT I UNDERSTAND ALL HIPAA, FINANCIAL AND COMMUNICATION POLICIES AS OUTLINED ABOVE AND THAT THE HEALTH AND DENTAL INFORMATION THAT I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT NAME: _____ **DATE:** _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____