MEDICAL UPDATE

PATIENTS'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL (PLEASE PRINT): _____

HOME #: _____ CELL#_____ WORK #: _____

DOB: _____ SEX: _____

ARE YOU A FULL TIME COLLEGE STUDENT? NAME OF SCHOOL AND CITY: _____

Insurance Information

NAME OF INSURANCE: _____ ID #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

INSURANCE PHONE #: _____ EMPLOYERS NAME: _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

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

_____

NAME AND PHONE # OF PHYSICIAN: _____

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

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 POLICIES and COMMUNICATION 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: _____