AMELIA Perfect Smile

New Patient Registration

Thank you for selecting Amelia Perfect Smile!
New Patients, please fill out this form completely.

Patient Information

First Name:_____ Last Name:_____ MI:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

Sex: Male ❑ Female ❑ Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Birthdate:_____ Age:_____ Soc. Sec:_____ Driver Lic:_____

Email:_____ ❑ I would like to receive correspondence via email

Pharmacy:_____ Who can we thank for referring you?_____

Employment Status: Full Time ❑ Part Time ❑ Retired ❑ Student Status: Full Time ❑ Part time ❑

Patient's Employer: _____ Work Phone:_____

Responsible Party (if someone other than patient)

First Name:_____ Last Name:_____ MI: _____

Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Birthdate:_____ Soc. Sec:_____ Driver Lic:_____

❑ Responsible Party is also a Policy Holder for Patient ❑ Primary Insurance Policy Holder ❑ Secondary Insurance Policy Holder

Primary Insurance Information

Relationship to Insured ❑ Self ❑ Spouse ❑ Other ❑ Child

Name of Insured:_____ Ins. Company:_____

Insured Date of Birth:_____ Address:_____

Insured Soc. Sec/ID# _____ Address 2:_____

Group #_____ City, State, Zip:_____

Employer:_____ Ins. Phone #_____

Secondary Insurance Information

Relationship to Insured ❑ Self ❑ Spouse ❑ Other ❑ Child

Name of Insured:_____ Ins. Company:_____

Insured Date of Birth:_____ Address:_____

Insured Soc. Sec/ID# _____ Address 2:_____

Group #_____ City, State, Zip:_____

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Medical History

Patient's Name:_____ Date of Birth:_____

Address:_____ Contact Phone #:_____

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, explain:_____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes, explain:_____
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes, explain:_____
Are you taking any medication, pills, or prescription drugs?	○ Yes	○ No	If yes, explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If yes, explain:_____
Are you on a special diet?	○ Yes	○ No	If yes, explain:_____
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	

Women: Are you ❑ Pregnant or ❑ Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptive

Are you allergic to any of the following? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex

Local Anesthetics ❑ Other (Please specify) _____

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

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

*Condition may require medication.

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please specify_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT/PARENT/ OR GUARDIAN DATE

_____

DOCTOR'S SIGNATURE DATE

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	Yes	No
May we leave a message on your answering machine at home or on your cell phone?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Dental History

Date of last dental visit? _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ❑Yes ❑No

How often do you floss your teeth? _____

Do your gums bleed when you brush? ❑Yes ❑No

Have you ever been treated for periodontal disease? ❑Yes ❑No

Do you grind or clench your teeth? ❑Yes ❑No

Do you have sores, blisters or swelling on your gums lips or cheeks? ❑ Yes ❑No

Have you ever had orthodontic treatment? ❑Yes ❑No

Have you had your wisdom teeth removed? ❑ Yes ❑No

Do you have problems with bad breath? ❑Yes ❑No

Have you ever used an electric toothbrush? ❑Yes ❑No

Are your teeth sensitive to hot, cold or pressure? ❑Yes ❑No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change your smile you would:

- ❑ Make it brighter
- ❑ Make it straighter
- ❑ Close spaces
- ❑ Replace metal fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Repair Missing
- ❑ Replace old crowns that don't match
- ❑ Have a smile makeover

Comments or Concerns: _____

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

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Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign.

General: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, test, office procedures, medications and also any other services not directly provided by the dentist.

Insurance: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balances is your responsibility whether or not your insurance company pays any portion.

Payment: FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYS and DEDUCTABLES are due at the time of service unless other arrangements are made. Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility of payment and fees. Once your insurances have paid their portion, you will receive an explanation of their payment and your responsibility. We will receive the same information. We have implemented a policy requiring that we keep a cred/debit card on file for settlement of account balances. Should your balance remain unpaid it will automatically be charged to the credit card on your account. If we are unable to obtain approval on the card 14 days your account will be assessed a financial charge of 18%. A receipt will be mailed to you immediately. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible for paying all cost of collections, including attorney fees.

By signing this Financial Agreement, I understand and agree that you authorize MY INSURANCE CARRIER TO PAY BENEFITS DIRECTLY TO J. Bradley Hall, D.M.D. further acknowledge that any insurance benefits when received will be credited to my account in accordance with my insurance company's assignment.

I have read, understand and agree to the terms and conditions of the Financial Agreement.

_____

Signature of Patient/Parent or Guardian Date

Credit Card Information

Please provide credit card of choice for automatic payments.

Name on Card: _____

Card Number: _____

Expiration: _____ Security Code: _____

Signature: _____

The information is stored in a safe and secure place. It will be scanned into a HIPPA compliance program with a password.
Thank you for your cooperation in this matter.

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Missed Appointment Policy

We're glad you have chosen us to provide our dental care, but unfortunately if you miss your appointment, you will compromise that care.

A missed appointment is when you fail to show up for you an appointment without a phone call or cancel without at least a 24-hour business day notice. Our office hours are Monday-Thursday 8:00am-5:00pm.

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask you give us a courtesy call when you are unable to keep your appointment.

We require at least a 24-hours business day notice for appointment cancellations anything less than a 24- hour business day notice will incur a $35.00 cancellation fee. If your scheduled appointment exceeds an hour, then a $75.00 cancellation fee will occur.

Let's work together to provide you with the best possible care you deserve.

_____

Signature of Patient/Parent or Guardian Date