— HALL FAMILY —
DENTAL
MATT HALL, DDS

Thank you for choosing Hall Family Dental to help you with your oral health! We are excited to welcome you to the practice and want you to know we are here for YOU! Please don't hesitate to ask any member of our health care team if you have any questions. WELCOME!

New Patient Information Today's date: _____

Name: _____
First Middle Last

Birth Date: _____ Social Sec. Number: _____
Gender: _____ Driver's License: _____

Address: _____
Number and Street City and Zip

Cell phone: _____ Home phone: _____
Work phone: _____
Email Address: _____

Occupation: _____ Employer: _____
Marital Status: _____ Spouse (if married): _____

How did you hear about us? _____
If you were referred by a current patient, we would love to know who: _____
And, is it ok with you if we send that person a thank you note? _____

Whom would you like us to contact in case of emergency?
Name: _____ **Phone:** _____
Relationship: _____

If patient is a minor, list legally responsible party name, phone, and address: _____
_____

Financially responsible party name, phone, and address (if person other than patient): _____
_____

— HALL FAMILY —
DENTAL
MATT HALL, DDS

Dental Insurance Information

Name of insurance company: _____

Sponsor of the dental plan (employer, self, other): _____

Name of insured person: _____

Insured's date of birth: _____

Subscriber ID or SSN: _____

Relationship of patient to insured: _____

If you have secondary dental insurance, please provide information for that plan here:

Name of insurance company: _____

Sponsor of the dental plan (employer, self, other): _____

Name and date of birth of insured person: _____

Subscriber ID or SSN: _____

Relationship of patient to insured: _____

Email Communication

Unless you specifically ask that we email you information directly via unencrypted email, Hall Family Dental will use an encrypted email service. The exception to this practice is our appointment reminder system, which utilizes the minimum necessary information in reminders.

Telephone Contact

I consent to Hall Family Dental leaving brief messages on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication. I consent to the dental practice using my cellphone number to call or text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

Initial here: _____

Scheduling of Appointments

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are committed to providing you and all of our patients with the best possible care to help in achieving optimum oral health.

> **Please note: we are happy to reschedule your visit for any reason with 48 hours notice. This notice helps us maintain the utmost service and care for all of our patients whom we care about greatly!**

— HALL FAMILY —
DENTAL
MATT HALL, DDS

Financial Terms

Any co-payments, deductibles, and any services not covered by your insurance plan shall be due at the time the service is provided. We are happy to bill your insurance carrier, as a courtesy to you; please remember that the balance is your responsibility whether your insurance company pays or not. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy. Late changes to the schedule or a failure to show up for an appointment are subject to a $50 fee and returned checks are subject to a $25 fee.

By signing below, I agree to the following: (1) the dental team may perform any dental services that I may need and have consented to during diagnosis and treatment, including oral exams, cleanings, periodontal gum probings, and X-rays taken during appointments. (2) I have read the above and agree to the financial and scheduling terms, and (3) I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me, and (4) I agree to pay Hall Family Dental for treatment, preventative, and diagnostic care received through Hall Family Dental.

_____ (Initial) I acknowledge that I have received the Dental Materials Fact Sheet dated May 2004.

Signature: _____ Date: _____

— HALL FAMILY —
DENTAL
MATT HALL, DDS

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I have received a copy of the Hall Family Dental Notice of Privacy Practices.

_____[Please Print Name]

_____[Signature]

_____[Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program 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)

— HALL FAMILY —
DENTAL
MATT HALL, DDS

New Patient Confidential Health History Today's date: _____

Name: _____
First Middle Last

Medical Questions: Please circle appropriate answer (leave blank if you do not understand)

1. Yes / No Is your general health good?
   If no, explain: _____

2. Yes / No Has there been a change in your health within the last year?
   If yes, explain: _____

3. Yes / No Have you been to the hospital or been to the ER or had a serious illness in the last Three years? If yes, explain: _____

4. Yes / No Are you being treated by a physician now?
   If yes, explain: _____

5. Yes / No Are you in pain now?
   If yes, explain: _____

Have you ever experienced any of these?
Please circle if yes. Check here if NO TO ALL _____

Chest pain (angina)	Blood in stool	Frequent vomiting	Fainting spells
Diarrhea recurring	Jaundice	Frequent urination	Dry Mouth
Recent weight loss	Bruise easily	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing	Persistent cough
Swollen ankles	Bleeding problems	Blurred vision	Sinus problems
Shortness of breath	Blood in urine	Fevers, recurring or severe	
Constipation recurring	Headaches, recurring, severe, or one-sided		

Other: _____

Are you allergic to or have you had a reaction to any of the following?
Please circle if yes. Check here if NO TO ALL _____

Valium or other sedatives	Aspirin	Latex	Nitrous oxide
Penicillin/other antibiotics	Food	Local anesthetic	Metal

Other: _____

— HALL FAMILY —
DENTAL
MATT HALL, DDS

All Patients: Please circle appropriate answer.

1. Yes / No Do you have or have you had any other diseases or medical problems NOT listing on this form? If yes, explain: _____
2. Yes / No Have you ever been pre-medicated for dental treatment? If yes, explain: _____
3. Yes / No Have you ever taken Fen-Phen? If yes, when? _____
4. Yes / No Is there any issue or condition you would like to discuss with the dentist in private?

Have you ever had or do you currently have any of the following?

Please circle if yes. Check here if NO TO ALL _____

Heart Disease	AIDS/HIV	Psychiatric care	Surgeries
Family heart disease	Heart attack	Osteoporosis	Hospitalization
Thyroid disease	Artificial joint	Diabetes	Asthma
Heart defects	Tumors or cancer	Chemotherapy	Heart murmurs
Sexually transmitted disease	Herpes	Radiation	Rheumatic fever
Canker or cold sores	Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Liver disease	High blood pressure	Eye disease
Emphysema or lung disease	Seizures	Stroke	Transplants
Kidney or bladder disease	Cosmetic surgery	Eating disorders	Tuberculosis
Sleep apnea	Neurological disorder		

Please explain circled conditions: _____

_____

_____

Are you taking/ have you taken any of the following in the last three months?

Please circle if yes. Check here if NO TO ALL _____

Recreational drugs	Antibiotics	Alcohol	Supplements
Tobacco in any form	Weight loss medication	Herbal supplements	
Anti-depressants	Biphosphonate (Fosamax)	Over-the-counter medicines	

Please list all prescriptions and medications you are currently taking:

_____

_____

At-Home Oral Hygiene Care

How often do you brush your teeth? _____

How often do you floss? _____

— HALL FAMILY —
DENTAL
MATT HALL, DDS

Do you use mouthwash? Yes/No

If YES, which kind and how often? _____

Do you use any other dental home care products? Yes/No

If YES, which kind? _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

Circle Appropriate Answer (Leave blank if you do not understand the questions)

1. Are you currently experiencing dental pain or discomfort? Yes/No

If YES, explain: _____

2. Do your gums bleed? Yes/No

If YES, explain: _____

3. Are your teeth loose? Yes/No

If YES, explain: _____

4. Do you wear dentures or partials? Yes/No

If YES, explain: _____

5. Have you ever been told you have gum disease? Yes/No

If YES, explain: _____

6. Are your teeth sensitive to hot, cold, sweets or pressure? Yes/No

If YES, explain: _____

7. Have your ever had any clicking, popping or discomfort in the jaw? Yes/No

If YES, explain: _____

8. Do you brux or grind your teeth? Yes/No

If YES, explain: _____

9. Do you wear an occlusal guard? Yes/No

10. Have you ever had orthodontic treatment (braces) before? Yes/No

If YES, explain: _____

11. Do you have dry mouth? Yes/No

If YES, explain: _____

12. Does food or floss catch between your teeth? Yes/No

If YES, explain: _____

— HALL FAMILY —
DENTAL
MATT HALL, DDS

13. Have you had any problems or upsetting experience with previous dental care? Yes/No

If YES, explain: _____

14. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No

If YES, explain: _____

15. Have you ever been pre-medicated for dental treatment? Yes/No

If YES, explain: _____

16. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No

If YES, explain: _____

17. Are you happy with your smile? Yes/No

If NO, please explain: _____

18. What would you change about the present condition of your mouth? _____

_____

19. Is there anything else you would like us to know about your dental health? Yes/No

If YES, explain: _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's signature: _____ Date: _____

Physician's name: _____ Phone: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ Date: _____

Signature of patient (parent of guardian)

_____ Date: _____

Signature of Dentist