Belle Hall Dentistry
Family and Cosmetic

Thank you for choosing Belle Hall Dentistry. Please fill out this form completely to ensure that we provide you with the best possible service.

Patient Name				Social Security #
Date of Birth	Email Address			Home Phone
Address				Work Phone
City	State	Zip Code		Mobile Phone

Referred by?

Primary Care Physician

Employer		Occupation	
Address	City	State	Zip Code

Primary Insurance Provider	**Secondary Insurance Provider**
Effective Date	Effective Date
Policy Number	Policy Number
Group Number	Group Number
Contact Number	Contact Number

Please fill out the items below if you are covered under the policy of a spouse, partner, parent or legal guardian.

Patient Name				Social Security #
Date of Birth	Email Address			Home Phone
Address				Work Phone
City	State	Zip Code		Mobile Phone
Employer				Occupation

Medical and Dental History

Previous Dentist	Date of Last Cleaning
Describe any dental problems you may have.	
Have you ever had complications following dental treatment? If so, please tell us about it.	
Describe anything that bothers you about the appearance of your teeth, smile or face.	

Do any of the following items apply to you?

- ☐ Pregnant or Possibly Pregnant
- ☐ Drink Coffee (Amount?)
- ☐ Use Tobacco (Amount?)
- ☐ High Blood Pressure
- ☐ Chest Pains/Heart Attack
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Prosthetic Devices
- ☐ Lung Disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Allergies/Hay Fever
- ☐ Sinus Problems
- ☐ Frequent Headaches
- ☐ Clinching or Grinding Teeth
- ☐ Mouth Ulcers/Sores
- ☐ Mouth Breathing
- ☐ Excessive Snoring
- ☐ Fear of Dental Treatment
- ☐ Orthodontic Treatment
- ☐ History of TMJ
- ☐ Sore, Tender or Stiff Jaws
- ☐ Connective Tissue Disease
- ☐ Osteoporosis
- ☐ Issues with Jaw Joints
- ☐ Hepatits or Liver Disease
- ☐ Kidney or Blatter Disease
- ☐ Thyroid Problems
- ☐ Sexually Transmitted Diseases
- ☐ Arthritis or Rheumatism
- ☐ Cancer (Type?)
- ☐ Easy to Bleed or Bruise
- ☐ Glaucoma
- ☐ Epilepsy, Convulsions or Seizures
- ☐ Psychiatric Therapy
- ☐ HIV Circle
- ☐ Past Surgeries:

Please list all medications you take.

Are you allergic to any medications? If so, please list them.

This space for office use only:
Updates/Notes:

By signing this document, you acknowledge that the information provided on this form is accurate and complete to the best of your knowledge.

Patient/Legal Guardian Signature	Date

Consent for Services, Communication and Disclosure

Consent for Service

In consideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services. I further agree that the reasonable value of services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder. I grant my permission to be contacted by phone, email or postal service to discuss matters related to my dental services.

Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy at any time by request.

Consent for Use and Disclosure of Health Information

By signing this form, I am also giving my consent to your use and disclosure of my protected health information to carry out our treatment, payment activities and health care operations. I have read the information regarding patient information, services, communication and disclosure. I grant Belle Hall Dentistry permission to utilize or forward such information to other health care professionals per needed referrals for additional treatment in compliance with HIPPA.

Signature of Patient, Parent or Guardian Date

_____ _____

Financial Agreement

As a service to our patients, we file all dental insurance claims. We accept all insurance companies and we are in network with **Delta Dental and Metlife**. Patients will be responsible for paying any balance remaining after insurance pays. Outstanding balances should be made within 30 days after insurance pays unless prior financial arrangements have been made with our financial coordinator. There are financing options available here at Belle Hall Dentistry:

- Care Credit (up to 18 months)
- In-Office Financing
- Auto Payment Draft (credit or debit)

With these financing options, patients may be able to receive up to 18 months interest free. Patients may pay by cash, check, credit card (Visa, Master Card, Discover), HSA/Flex Spending or Care Credit with proper identification. Prepayment discounts are also available.

Office Policy

Office Hours
Monday and Wednesday
7:00AM - 4:00PM
Tuesday and Thursday
8:00AM - 5:00PM
Friday
8:00AM - 1:00PM

Scheduling appointments and changing appointments can be done by phone (within business hours) or by email. We ask our patients to give us at least 24 hours notices to reschedule an appointment. We realize that unexpected things can happen, but we ask for advanced notice when possible.

The following will apply to missed appointments:

- 1st missed appointment - no charge
- 2nd missed appointment - $25 charge
- 3rd missed appointment - $25 charge (possible dismissal from the practice)

If you have any questions concerning our financial agreement or office policy, please feel free to ask. Thank you for choosing us for your dental needs.

By signing your name below, you certify that you have read the above information. Any questions concerning these policies have been discussed. Your signature also certifies your understanding of and agreement with the above policies. You understand you are responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

Signature of Patient, Parent or Guardian _____ Date _____