Hall & Butterfield
FAMILY DENTISTRY
ROBERT B. HALL, JR., D.D.S. • TERRY A. BUTTERFIELD, D.D.S.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Home Phone (____) _____ Cell Phone (____) _____

Name _____ Do you accept text messages? _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ Soc. Sec. # _____

State _____ Zip _____ Driver's License # _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Married ❑ Widowed ❑ Single ❑ Minor

Name of Pharmacy _____ ❑ Separated ❑ Divorced ❑ Partnered for ____years

Patient Employer/School _____ Occupation _____

Patient Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State ___ Zip _____

Responsible Party Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company & Address _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependants covered under this plan _____

AUTHORIZATION (PLEASE READ ENTIRE PARAGRAPH AND SIGN BELOW)

I certify that I, and/or my dependant(s), have insured coverage with _____ and assign directly to Dr. Hall and Dr. Butterfield all insurance benefits, if any, otherwise payable to me for sevices rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** I authorize the use of my signature on all insurance submissions.

Drs. Hall & Butterfield may use my health care information with the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

If I do not pay the entire balance within 30 days from the date of service, a late charge of 1.5% will be assessed each month. I realize that failure to keep this account current may result in inability to receive additional dental services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees (35%) incurred in attempt to collect on this account. There will be a $25.00 returned check fee for all returned checks. There will be a $50.00 fee for broken appointments or cancelled appointments without 24 hour notice.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with the following:

❑ Bad breath	❑ Grinding teeth	❑ Sensitivity to hot
❑ Bleeding gums	❑ Loose teeth or broken fillings	❑ Sensitivity to sweets
❑ Clicking or popping jaw	❑ Periodontal treatment	❑ Sensitivity when biting
❑ Food collection between teeth	❑ Sensitivity to cold	❑ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Frequency of sugar exposures / day (sugary drinks, soda, candy, etc.): _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Are you under a Physician's care now? ❍ Yes ❍ No ❍ N/A _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No ❍ N/A _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No ❍ N/A _____

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No ❍ N/A _____

Do you take or have taken Bisphophanates (aredia, fosamax)? ❍ Yes ❍ No ❍ N/A

Do you use tobacco? ❍ Yes ❍ No ❍ N/A

Are you on a special diet? ❍ Yes ❍ No ❍ N/A

Do you use controlled substances? ❍ Yes ❍ No ❍ N/A

Women: Are you ❑ Pregnant: ___ trimester ❑ Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other _____

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

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

Have you ever had any serious illness not listed above? ❍ Yes ❍ No ❍ N/A

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I acknowledge that I received a copy of the HIPPA Privacy notice.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Relationship to Patient