HARTSELLE FAMILY DENTISTRY, LLC

256-773-0800

PATIENT REGISTRATION

Maggie McKelvey, D.M.D
Ashley Holladay, D.M.D

Patient Information

First Name: _____Last Name: _____

Address: _____Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Work Phone: _____Cell:_____

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

Birthdate: _____S.S.N: _____Driver Lic: _____

Email: _____(If you would like to receive reminders by email)

Employer: _____

How did you hear about our office? (please circle one)

Internet(google) Billboard Our Website Social Media Our Location Other:_____

Responsible Party Information (If different from Patient)

First Name: _____ Last Name: _____

Relationship to Patient: _____

Address: _____Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Work Phone: _____ Cell: _____

Birthdate: _____ S.S.N. _____ Driver Lic: _____

Employer: _____

Primary Insurance Information

Insurance Company: _____

Name of Policyholder: _____Birthdate: _____

S.S.N. _____Employer: _____

Medical History Form

Patient Name: _____ DOB: _____ Date Created: _____

General Questions:	**Please Circle One**	
Are you under a physician's care now?	Yes	No
If yes, please list Dr. Info:		
Have you ever been hospitalized or had a major operation?	Yes	No
If Yes, please explain:		
Have you ever had a serious head or neck injury?	Yes	No
If yes, please explain:		
Are you taking any medications, pills or drugs?	Yes	No
If yes, please list:		
Do you use controlled substances?	Yes	No
Do you use tobacco	Yes	No
Have you had any joint replacement?	Yes	No
(If yes, Do you take pre-medication (antibiotics)?	Yes	No
Do you have sleep apnea?	Yes	No
Do you use a sleep appliance?	Yes	No
Do you have dry mouth?	Yes	No

When was the last time you have seen a dentist and what procedures were done? Please answer below.

Women: Are you pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other

If **OTHER** allergy is checked, please identify the allergy below.

Do you have or have you had any of the following? **Circle Any that apply**

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis C	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Emphysema
High Blood Press	Arthritis/Gout	Epilepsy or Seizures	High Cholesterol
Artificial Heart Valve	Excessive Bleeding	Shingles	Artificial Joint
Excessive Thirst	Hypoglycemia	Asthma	Fainting Spells/Dizziness
Irregular Heartbeat	Sinus Trouble	Blood Disease	Kidney Problems
Blood Transfusion	Leukemia	Stomach/Intestinal Disease	Breathing Problems
Frequent Headaches	Liver Disease	Stroke	Bruise Easily
Low Blood Pressure	Cancer	Glaucoma	Lung Disease
Thyroid Disease	Chemotherapy	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores	Heart Murmur	Pain in Jaw Joints	Congenital Heart Disorder
Heart Pacemaker	Parathyroid Disease	Ulcers	Convulsions
Heart Disease	Psychiatric Care		

Have you ever had any serious illness or injuries not listed? (Please explain)

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.

X_____Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

*****You May Refuse to Sign this Acknowledgement****

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

x_____Signature _____ Date

_____ Please Print your name here

Authorization to release information

Purpose: This form is used to obtain authorization to release your information covered under the Privacy Act to people other than yourself. I _____
Authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____

{Please Print Name and Relationship}

_____

{Please Print Name and Relationship}

_____

{Please Print Name and Relationship}

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from the patient, but it could not be obtained because:

1. The patient refused to sign.
2. Due to an emergency situation, it was not possible to obtain acknowledgement.
3. We weren't able to communicate with patient.

Employee Signature: _____

Hartselle Family Dentistry, LLC
Dr. Maggie McKelvey and Dr. Ashley Holladay
1511 Highway 31 SW
Hartselle, AL 35640

PLEASE READ THESE PAGES CAREFULLY THEN SIGN:

By signing this form, I do hereby give permission for all dental treatment by or under the supervision of the dentist(s) above.

I consent to the release of patient information to my insurance company for processing of my claims.
I also consent for the release of my information for outside referral specialists.
I authorize the use of email and/or electronic messaging to contact me in relation to my dental care.

I agree to pay fees in the usually and customary manner, and I understand that fees for an office visit must be paid at the time of the visit unless an agreement has been made with the collection department prior to the visit. I also understand that I, AND NOT MY INSRUANCE COMPANY, AM RESPONSIBLE FOR ANY DENTAL FEES.

I agree and understand that any fees that are not paid at the time of the visit, or at the time agreed upon between the collection department and me, if applicable, will bear interest at the rate of 5% per annum. I also understand and agree that if I do not pay these fees as I have agreed, I will be responsible and obligated to reimburse this dental practice for all costs and expenses (including, without limitation, attorney's fees and charges) reasonably incurred by this dental practice in enforcing or collecting, or attempting to enforce or collect the fees.

NON-COVERED ROUTINE SERVICE POLICY:

We file your insurance as a courtesy. Dental insurance is a contract between the employer and the patient. It has no connection at all to us as your dental office. The extent of coverage varies greatly from company to company, sometimes even within a company. It has absolutely nothing to do with the level of service provided by us, and the fee charged for these services. We want to provide you with the best dental care possible. There may be routine services and cost that may not be covered by your dental contract. You will be responsible for any remaining balance that your insurance does not pay in full. We estimate your portion based on the most up to date information we have, but it is only an estimate. It is **IMPOSSIBLE** to give you a guaranteed quote at the time of service. However, we will make every effort to be as accurate as possible.

TERMINATION OF TREATMENT:

By signing this form, I hereby understand and agree that the dentists in this practice may terminate the dentist-patient relationship. We base our relationship on mutual respect between the dentist and the patient, and any event or action by the patient, which disturbs this trust, including significant failure to comply with our treatment recommendations, failure to take responsibility for payment of fees, knowingly falsifying information or other actions not mentioned here will result in a termination of our relationship.

NOTE FOR BLUE CROSS PREFERRED PATIENTS:

When receiving a posterior composite restoration, you are responsible for paying the difference between the Blue Cross allowance for the amalgam and the PDP fee schedule for the posterior complete.

POLICY CONCERNING DIVORCE SETTLEMENTS:

The policy of this dental practice is that the person signing as the responsible party for the child of divorced parents must arrange for the payment to be made at the time of the child's office visit. Regardless of the terms of your divorce settlement, whoever brings the child in must pay for the office visit at that time.

CANCELLATION/MISSED APPOINTMENT POLICY:

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a **Cancellation/Missed Appointment Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows: We require that you give our office **48 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $75 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments will be made until this fee is paid.

If a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $75 cancellation fee will be charged.

Treatment Appointment Policy: All treatment appointments requiring an extended scheduled time will need to be secured with a debit/credit card in order to schedule your appointment. If the appointment is missed, the patient is more than 15 minutes late, or the appointment is not rescheduled within the 48 hour allowed time, the fee of $75 will be charged to the Responsible Party. After the first missed appointment, future treatment appointments will require a 50% nonrefundable deposit in order to schedule.

If you have any questions regarding these policies, please let our office staff know and we will be glad to clarify any questions you have.

I have read and understand the Cancellation/Missed Appointment Policy and the Treatment Policy of the practice and I agree to be bound by their terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I acknowledge that I have received a copy of Hartselle Family Dentistry's Cancellation/Missed Appointment Policy and Treatment Policy. We welcome you to our family and look forward to helping you obtain and maintain the healthy, beautiful smile you deserve. If there is anything we can do to better serve you, please do not hesitate to ask any of our staff.

Signature of Patient **Date**