PATIENT REGISTRATION - HARTSELLE FAMILY DENTISTRY, LLC
256-773-0800

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

Welcome to our office! To help us serve you, please complete this confidential form. This information is important to your dental health!

PATIENT INFORMATION

First Name: _____Preferred: _____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: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company: _____

Name of Policyholder: _____Birthdate: _____

S.S.N. _____Employer: _____

ALLERGIES - Circle Any That Apply

Latex

Penicillin or Other Antibiotics

Local Anesthetics (Novocain)

Codeine or Other Narcotics

Sulfa Drugs

Barbiturates, Sedatives, or Sleeping Pills

Aspirin

Other: _____

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING: Circle Any That Apply

Aspirin
Controlled Substances
Anticoagulants (Blood Thinners)
Antibiotics or Sulfa Drugs
High Blood Pressure Medicine
Insulin, Orinase, or other Diabetes Drugs
Nitroglycerin
Cortisone or Other Steroids
Osteoporosis (bone density) Medication
Other: (Please provide current list or medications or list here)

_____

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? Circle Any That Apply

Cancer/Tumor	Rheumatic fever	High or Low Blood Pressure
Current Cancer Treatment	Artificial Valve or Joint	Pacemaker
Heart Disease/Defect	Antibiotics for Artificial Joint	Lung Problems
Heart Murmur	Tuberculosis	Stroke
Mitral Valve Prolapse	Osteoporosis	Stomach/Intestine Disorder
Kidney Disease	Hepatitis	Liver Disease
Alcoholism	Drug Addiction	Diabetes
Neurologic Condition	Epilepsy	Seizures
Fainting Spells	Psychological Disorder	Current Psychiatric Care
Arthritis	Herpes or Cold Sores	AIDS/HIV Positive
Migraines/Frequent Headaches	Blood Disorders	Chronic Sinus Trouble
Asthma	History or Anaphylaxis	Chronic Allergies or Hives
Cigarettes/Tobacco	Vape, E- Cigarette, Juul, etc	Sleep Apnea or Snoring
Dry Mouth		

Any disease or condition not listed above: _____

WOMEN: Circle Any That Apply

Possibly Pregnant

Breastfeeding

Pregnant – Due Date _____

Taking Hormones or Contraceptives

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

_____Print Name H

This form is used to obtain authorization to release your information covered under the Privacy Act to people other than yourself: Please list any person(s) that you authorize to have access to protected information:

{Please Print Name and Relationship}

{Please Print Name and Relationship}

Procedures and Policies

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.

Late and Missed Appointment Policy

At Hartselle Family Dentistry, we put our faith in you to keep your appointment. When we set up an appointment, a certain amount of time is reserved specifically for you. Many offices double or even triple book their schedule to prevent from being financially damaged as a result of a missed appointment. However, double booking appointments does not allow us to give the care and attention needed to provide excellent quality dentistry and for this reason **we choose not to do it**. When a patient cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who is also needing dental care.

Our policy is as follows: We require that you give our office **24-hour notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment.

- **1st Missed Appointment:** If an appointment is missed or canceled a letter will be sent to your home reminding you of our policy and the effects of your missed appointment. We also reserve the right to chart you a $75 missed appointment fee as well as additional charges of $25 for each ½ hour of appointment time scheduled. This fee is at the discretion of our office manager and the reason for your missed appointment.
- **2nd Missed Appointment:** After your second missed appointment, another letter will be sent to your home notifying you of a change in your account status as well as a statement for the missed appointment fees listed in the 1st missed appointment status. In order for you to schedule future appointments with out doctors a deposit must be made. The deposit is 50% of the treatment scheduled on the appointment. This will be collected the day you schedule the appointment. If the patient does not show up for that appointment the deposit is non-refundable. If you choose not to pay a deposit then appointments will only be schedule via our short notice list, in which we will notify you of last-minute appointment opportunities.

  For all hygiene/preventative appointments after a 2nd missed appointment, the patient will be placed on a short notice list and will be notified when there are openings on the schedule. No hygiene appointments will be scheduled ahead of time until the patient's account is placed back in good standing. That decision is base at the *sole discretion of the office manager* as she handles all of our accounts.

Late Arrivals: When we reserve time for you, we require ALL of that time to provide you with the best quality dentistry as possible. When you are later that inhibits our ability to accomplish this. If you arrive more than 15 minutes late, your appointment will be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment and the fees will still apply.

We understand that true emergencies happen. If this is the case, please provide us with a doctor's note or other adequate proof and the missed appointment will be removed from your accounts record.

I have read the policy above and I understand and agree to the listed 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_____ Date_____