HALLMARK Dentistry

Patient Information **Today's Date: _____**

Name: _____ SS#:_____

Date of Birth: _____ Sex: Male or Female Occupation: _____

Street Address: _____

City: _____ State: _____ Zip:_____

Phone: Home: _____ Cell: _____ Work: _____

Emergency Contact: _____Phone: _____

Dental Insurance Information

Insurance Co: _____ **Subscriber Name**: _____

Subscriber DOB: _____ **Contract ID:** _____ **Group Number:** _____

Secondary Insurance Company: _____ **Subscriber Name:** _____

Subscriber DOB: _____ **Contract ID:** _____ **Group Number:** _____

Please circle any of the following that apply:

High/Low Blood Pressure	Systemic Lupus	Epilepsy/ Neurological Disorders
Joint Replacement	Asthma	Diabetes
Osteoporosis	Cancer/Chemo/Radiation	Seizures
Cardiovascular Disease	Reflux/Persistent Heartburn	Mental Health Disorder
Pacemaker	Gastrointestinal Disease	Migraines
Congestive Heart Failure	Liver Disease/Hepatitis	Recurrent Infections
Arteriosclerosis	Kidney Problems	Ulcers
Heart Attack	Sexually Transmitted Disease	Malnutrition
Other Congenital Heart Defects	Glaucoma	Hemophilia
Tuberculosis	Arthritis	Rheumatic Fever
Paget's Disease	AIDS or HIV Infection	Rheumatic Heart Disease
Autoimmune Disease	Anemia	Emphysema
Thyroid Problems	Stroke	Chronic Pain
Smoking	Pregnant	Controlled Substances

Please explain any circled conditions or if you have anything not mentioned:

_____

_____

_____

Current Medications: (include vitamins, natural or herbal preparations and/or diet supplements)

_____

_____

Have you or are you taking any medications (such as: Reclast, Fosamax or Prolia) to treat OSTEOPOROSIS? (This could include quarterly/yearly injection or weekly/monthly pill) Yes/ No

If yes, what medications are you taking? _____

Allergies – Are you allergic to or have you had a reaction to:

Local Anesthetics	Yes/No
Aspirin	Yes/No
Penicillin or other antibiotics	Yes/No
Barbiturates/ sedatives/ sleeping pills	Yes/No
Sulfa drugs	Yes/No
Codeine or other narcotics	Yes/No
Metals	Yes/No
Latex	Yes/No
Iodine	Yes/No

Other: _____

Have you had any of the following conditions?

Artificial (prosthetic) heart valve	Yes/No
Previous Infective Endocarditis	Yes/No
Damaged valves in transplanted heart	Yes/No
Congenital heart disease (CHD)	
Unrepaired, cyanotic CHD	Yes/No
Repaired (Completely) in last 6 months	Yes/No
Repaired CHD with residual defects	Yes/No

What is the reason for your visit today? _____

How do you feel about your smile? _____

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental x-rays:_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors of omissions that I may have made in the completion of this form.

Signature or Patient/Legal Guardian: _____ Date: _____

HALLMARK Dentistry

Financial Agreement

Thank you for choosing Hallmark Dentistry for your dental care and cosmetic dental needs. It is our policy to make definite financial arrangements with you prior to your treatment visit. The following is an explanation of our payment procedures and office polices. If you have any questions, please do not hesitate to ask.

Payment Agreement:

 Insurance: Your insurance benefits are a contract between you and your insurance carrier. The amount of coverage you receive will depend on the quality of the plan purchased by you or your employer; not the fees of the practice. The Practice will be happy to file your insurance as a courtesy to you; however, we ask that you please furnish the correct insurance information.

 In the event your insurance company has not paid their portion in 60 days, then the balance becomes your responsibility.

 If the Practice cannot verify insurance benefits eligibility for you prior to treatment or if no insurance is on file, then payment in full is required at the time services are rendered.

 Payment: Unless other arrangements are made prior to service, I agree to pay all deductibles, co-pays, **and the patient "estimated" portion** in full at the time of service. I authorize payment by my insurance company directly to the Practice. We accept cash, checks, Visa, MasterCard, AMEX and Discover. All return checks will subject to a $35 return check fee. Payment plans and financing are offered through Care Credit.

 Children: You are responsible to send payment for dependents not accompanied by an adult. The parent or guardian who brings the child to the appointment will be responsible for payment **regardless** of what a divorce decree may say. Reimbursement must be made between the two parents; we will not intervene.

- **Emergency Visits:** If you are not a registered patient of record, payment in full is required at the time services are rendered. Any dental insurance will be filed as a courtesy for your reimbursement.
- **Cancelled/Missed Appointments: Appointments cancelled within 24 hours or no showed will be subject to a $25.00/ hour charge. After 3 missed appointments, we will no longer be able to reserve time on our schedule for you.**
- **Prepayment: At the discretion of the office, certain appointments may require prepayment to reserve the appointment.**
- **Delinquent Accounts**: *At 90 days past due, I agree to the extent permitted by law, that if my account balance is referred to an agency or attorney(s) for collection purposes, to pay reasonable fees, expenses, or costs relating to the collection proceeding. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable.*

Who Will Be Responsible For Your Account:

Full Name: _____ DOB: _____

Street Address: _____ SSN#:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer Name: _____ Bus. Tel :_____ DL #:_____

I have read this form and had an opportunity to ask questions. I agree to the terms of this agreement. No modifications apply to this document.

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____ Date: _____

Sonya Hallmark, DMD
Hallmark Dentistry

HALLMARK Dentistry

HIPPA RELEASE FORM

I, _____, authorize the release information of
(PRINT PATIENT/GUARDIAN NAME)
_____, including the diagnosis, records, examination and
(PRINT PATIENT NAME)
treatment rendered to the above patient, ledger and billing and claims information.

This information may be released to the following individuals:

Name	Relationship to Patient	Phone Number

The best number to contact me at is: (_____) _____-_____

This release of information will remain in effect until terminated to me in writing.

In addition, I understand that my records may be released to another provider as requested by the provider's office in circumstances where this is necessary. This may include a referral to a specialist (such as endodontist, oral surgeon, periodontist or orthodontist) or a request from another office for an upcoming visit that I have scheduled.

Signed: _____ Date: _____/_____/_____