## Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.

If you have any questions or need assistance, please ask us and we will be happy to help.

# elcome

Name   Na	Patient Information (Confidential)		Patient
SS/SIN   Birthdate   Home Phone    Address   City   Prov   RE    Femall   Cell Phone    Check Appropriate Box   Minor   Single   Married   Separated   Divorced   Widowed    Student, Name of School/College   City   Prov   Prov   Pall Time   Part Time    Patient or Parent/Guardian's Employer   Work Phone    State/ Prov   Prov   Pall Time   Part Time    Patient or Parent/Guardian's Name   Employer   Work Phone    Spouse or Parent/Guardian's Name   Employer   Work Phone    Whom May We Thank for Reterring You?   Person to Contact in Case of Emergency   Phone    Responsible Party   Relationship to the Patient   To Patient    Address   Birthdate   Financial Institution    Employer   Work Phone   Ses/SIN    Is this Person Currently a Patient in our Office?   Yes   No    For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.    Cash   Parsonal Check   Credit Card   VISA   Master Card   I wish to discuss the office's payment policy.    Insurance Information   Relationship to Patient   Prov   Prov   Prov    Employer   State/ Prov   Pr	Tatient information (Confidential)		
City	Name	190 HATO ONE SELECT	Date
Cell Phone	SS#/SIN	Birthdate	Home Phone
Check Appropriate Box   Minor   Single   Married   Separated   Divorced   Widoved   Fall Time   Part T	Address	City	State/ Zip/ Prov P.C
Check Appropriate Box   Minor   Single   Married   Separated   Divorced   Widoved   Fall Time   Part T	Email	A STATE OF THE STATE OF	Cell Phone
Student, Name of School/College	Check Appropriate Box: Minor Single	☐ Married ☐ Separated	Divorced Widowed
Business Address   Enployer   Work Phone    Spouse or Parent/Quardian's Name   Employer   Work Phone    Person to Contact in Case of Emergency   Phone    Responsible Party   Relationship to Patient    Address   Home Phone    Email   Cell Phone    Email   Cell Phone    Driver's License #   Birthdate   Financial Institution    Employer   Work Phone   SS#/SIN    Is this Person Currently a Patient in our Office?   Yes   No    For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.      Cash   Personal Check   Credit Card   VISA   MasterCard   I wish to discuss the office's payment policy.      Insurance Information    Name of Insured   SS#/SIN   Date Employed    Birthdate   SS#/SIN   Date Employed    Birthdate   SS#/SIN   Date Employed    Name of Employer Address   City   Prov.   P.C.    Insurance Company   Group # Policy/ID#    Name of Insured   Work Phone    State/ Prov.   P.C.    State/ Prov.   P.C.    Insurance Company   Date Employed    Name of Insured   Sy#/SIN   Date Employed    Name of Insured   Date Employed    Name of Insured   Sy#/SIN   Date Employed    Name of Insured   Sy#/SIN   Date Employed    Name of Employer   Da		City	State/ Full Time Part Till
Spouse or Parent/Guardian's Name   Employer   Work Phone   Whom May We Thank for Referring You? Person to Contact in Case of Emergency   Phone   Responsible Party Name of Person Responsible for this Account   Parent   Address   Home Phone   Email   Cell Phone	Patient or Parent/Guardian's Employer	ug Street per true	Work Phone
Whom May We Thank for Referring You?  Person to Contact in Case of Emergency  Responsible Party Name of Person Responsible for this Account  Insurance Information Name of Employer  Work Pone  St#/SIN  Date Employer  Union or Local #  Work Pone  State/  Employer  Union or Local #  Work Pone  State/  State/  State/  State/  State/  Prov.  Relationship to Patient  Home Phone  State/  Financial Insurance  St#/SIN  Relationship to Patient  Insurance Company Insurance Company Insurance Insured  Name of Insured  State/  State/ St			State/ Zip/ Prov P.C
Responsible Party Name of Person Responsible for this Account Address	Spouse or Parent/Guardian's Name	Employer	Work Phone
Relationship to Pattent  Address	Whom May We Thank for Referring You?		Early of the Court
Relationship to Person Responsible for this Account to Person Responsible for this Account to Patient to Patie	Person to Contact in Case of Emergency		Phone
Relationship to Person Responsible for this Account to Person Responsible for this Account to Patient to Patie	Responsible Party		
Address	E. Britania Parkera Parkera Parkera	A TRACTICAL PROPERTY OF THE PR	HO CAN BUT 아니다
Birthdate Financial Institution  Employer			Home Phone
Birthdate Financial Institution  Employer	Email		
Employer	Driver's License #	Birthdate	
Is this Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.    Cash   Personal Check   Credit Card   VISA   MasterCard   I wish to discuss the office's payment policy.    Insurance Information   Relationship to Patient	Employer		
Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.  Insurance Information  Name of Insured	Is this Person Currently a Patient in our Office?	No	
Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.  Insurance Information  Name of Insured	For your convenience, we offer the following methods of p	payment. Please check the option	you prefer Payment in full at each appointment
Insurance Information  Name of Insured SS#/SIN Date Employed Work Phone State/ Zip/ Prov. P.C.  Insurance Company Group # Policy/ID# State/ Zip/ Prov. P.C.  How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit Date Employed  Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following  Name of Employer Work Phone State/ Zip/ Prov. P.C.  Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following  Name of Insured SS#/SIN Date Employed  Name of Employer Address City Prov. P.C.  Insurance Company Group # Policy/ID# State/ Zip/ Prov. P.C.  Insurance Company Group # Policy/ID# State/ Zip/ Prov. P.C.  Insurance Company F.C.  Insurance Company Prov. P.C.	20 <u>~~~</u>		
Name of Insured  SS#/SIN  Union or Local #  Work Phone  State/ Prov. Pro			
Birthdate SS#/SIN			있는데 1000mm 다른 항상 보다는데 하는데 하는데 하는데 하는데 하는데 하는데 하는데 하는데 하는데 하
Name of Employer	· · · · · · · · · · · · · · · · · · ·	91.9 LCC 1.9 (11.7 11)	to Patient
Employer Address City State/ Prov. Zip/ P.C.  Insurance Company Group # Policy/ID#  Ins. Co. Address City State/ Zip/ Prov. P.C.  How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit  Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following  Name of Insured SS#/SIN Date Employed  Name of Employer Union or Local # Work Phone State/ Zip/ Prov. P.C.  Insurance Company Group # Policy/ID#  State/ Zip/ Prov. P.C.  Insurance Company City Prov. P.C.			
Insurance Company Group # Policy/ID#		P. 20 20 STATE STA	
Ins. Co. Address City State/ Prov Zip/ Prov P.C		City	Prov. P.C.
How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit  Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following  Relationship to Patient  Date Employed  Name of Employer Union or Local # Work Phone  Employer Address City Prov. P.C.  Insurance Company Group # Policy/ID#  Ins. Co. Address City Prov. P.C.	Insurance Company	Group #	Policy/ID#
Name of Insured SS#/SIN Union or Local # Work Phone State/ Prov Policy/ID# State/ Prov Policy/ID# State/ Prov Pic State/ Prov State/ Prov	Ins. Co. Address	City	Prov P.C
Name of Insured	How Much is Your Deductible? How	w Much Have You Used?	Max. Annual Benefit
Name of Insured         to Patient           Birthdate         SS#/SIN           Name of Employer         Union or Local #           Employer Address         City           Insurance Company         Group #           Ins. Co. Address         City    To Patient  Work Phone  State/ Prov.  PC.  State/ Prov.  State/ Prov.  PC.	Do You Have Any Additional Insurance?	No If Yes, Complete the Follow	ring
Date Employed   Date Employed		100 00 00 00 00 00 00 00 00 00 00 00 00	
Name of Employer         Union or Local #         Work Phone State/ Prov.         Zip/ Prov.         Zip/ Prov.         Zip/ Prov.         P.C.           Insurance Company         Group #         Policy/ID# State/ Prov.         Zip/ Prov.         Zip/ Prov.         P.C.		Salarie School	
Employer Address         City         State/Prov.         Zip/Pcc.           Insurance Company         Group #         Policy/ID#           Ins. Co. Address         City         State/Prov.         Zip/Pcc.			
Insurance Company		4 400 05 96 06 50 0 50 1 60 60	
Ins. Co. Address City State/ Prov Prov Prov City State/ Prov Prov Prov Prov City State/ Prov		and selection alast the s	
		All the second of the second o	
	Files California S	UILY	Prov P.U

Patient Medical History									
Physician		Office	e Phone	F 40 10 10 10 10 10 10 10 10 10 10 10 10 10			Date of Last Exam		
		Yes	No	Buttitle				Yes	No
Are you under medical treatment now?			Ш	10. Are you				Ш	Ш
2. Have you ever been hospitalized for any surgical						-	r have you had any reactions to the following? .g. Novocain)	П	
operation or serious illness within the last 5 years?  If yes, please explain			Ш				er Antibiotics		
ii yes, piease explaiii				Sulfa Dru					
3. Are you taking any medication(s) including non-prescr	intian madiaina?			Barbitura					
If yes, what medication(s) are you taking?	iption medicine:			Sedative	S				
				lodine Aspirin				H	П
4. Have you ever taken Fen-Phen/Redux?					als (	e.a. nick	kel, mercury, etc.)	ō	
5. Have you ever taken Fosamax, Boniva, Actonel or any				Latex Ru			Part Control Control Control		
cancer medications containing bisphosphonates?				Other			10 Marie 1997 1997 1997 1997 1997 1997 1997 199		
6. Have you taken Viagra, Revatio, Cialis or Levitra in							stent cough or throat clearing not		
the last 24 hours?				associat	ed v	vith a kn	nown illness (lasting more than 3 weeks)?		Ш
7. Do you use tobacco?				13. Women (					
8. Do you use controlled substances?		П	П	Are you			think you may be pregnant?	Н	Н
Do you have or have you had any of the following?							contraceptives?	ō	
Yes No	0 (II D)			Y	es	No	Chart Pains	Yes	No
High Blood Pressure	Heart Disease			L			Chest Pains		
Heart Attack	Cardiac Pacen			123750000			Easily Winded		
Rheumatic Fever	Heart Murmur			-450 0,000			Stroke		
Swollen Ankles  Fainting/Seizures	Angina Frequently Tire	, d			_		Hay Fever/Allergies Tuberculosis		
Asthma	Anemia	tu					Radiation Therapy		Ä
Low Blood Pressure	Emphysema				7	П	Glaucoma		
Epilepsy/Convulsions	Cancer			25,000			Recent Weight Loss		
Leukemia	Arthritis			[			Liver Disease		
Diabetes	Joint Replacer	nent or	r Implant	. [			Heart Trouble		
Kidney Diseases	Hepatitis/Jaun			[			Respiratory Problems		
AIDS or HIV Infection	Sexually Trans	mitted	Disease				Mitral Valve Prolapse		
Thyroid Problem	Stomach Troub	oles/Ul	cers				Other		
Patient Dental History									
The state of the s							Date of Last Exam		
Name of Previous Dentist and Location	Yes	No		de titud han alle alle			Date of Last Exam	Yes	No
Do your gums bleed while brushing or flossing?				8. Do you	hav	e freque	ent headaches?		
<ol> <li>Are your teeth sensitive to hot or cold liquids/foods?</li> </ol>							rind your teeth?		
3. Are your teeth sensitive to sweet or sour liquids/food	s?						os or cheeks frequently?		
4. Do you feel pain to any of your teeth?						PROTECTION OF THE PARTY OF	any difficult extractions in the past?		
5. Do you have any sores or lumps in or near your mout	h? 🗆						any prolonged bleeding		
6. Have you had any head, neck or jaw injuries?				followin	ng e	xtraction	ns?		
7. Have you ever experienced any of the following				13. Have yo	ou h	ad any c	orthodontic treatment?		
problems in your jaw?				14. Do you	wea	ar dentu	res or partials?		
Clicking				If yes, o	late	of place	ement		
Pain (joint, ear, side of face)				15. Have yo	ou e	ver rece	eived oral hygiene instructions		
Difficulty in opening or closing				regardi	ng t	he care	of your teeth and gums?		
Difficulty in chewing	grade plants			16. Do you	like	your sm	nile?		
Authorization and Release									
I certify that I have read and understand the above information above questions have been accurately answered. I under information can be dangerous to my health. I authorize the discluding the diagnosis and the records of any treatment or a me or my child during the period of such Dental care to third practitioners. I authorize and request my insurance company	erstand that providing entist to release and examination render party payors and/o	ng inco y inforn ed to	orrect mation	that my denta responsible fo	l ins or pa	urance c yment of	oup insurance benefits otherwise payable to me. I carrier may pay less than the actual bill for servic f all services rendered on my behalf or my depen	es. I ag	
and roquest my moditance company	15 pay unoday			Signature of pat	ient	(or parent	t/guardian if minor)		
Doctor's Comments									
Doctor's comments			-						
Signature	~ 145						Date		

### LOGAN B HALL DDS PLLC 712 West Meadow Avenue Springdale, Arkansas 72764 479-751-4609

Patient Name:	Date:
Practices for Dr. Logan Hall.  I may refuse to sign.	opy of the currently effective Notice of Privacy nature; insurance change; patient reaches age of
<ul> <li>I understand that I may request a copy</li> <li>I understand that my PHI (Protected purposes of treatment and for payment</li> </ul>	Health Information) can and will be used for
PLEASE LIST ANY OTHER PARTIES VIDENTAL INFORMATION:	VHO CAN HAVE ACCESS TO YOUR
Name: Relationsh	ip: Phone:
Name: Relationsh	ip: Phone:
I AUTHORIZE CONTACT FROM THIS APPOINTMENTS, TREATMENT & BINFORMATION ABOUT MY DENTAL  Message on: Home Phone Compared Email U. S. Mail / Postcard	ILLING INFORMATION AND L HEALTH VIA:
☐ Any of the above  Please <i>print</i> your name	Please <u>sign</u> your name
☐ Patient ☐ Parent ☐ Guardian	□ Other

#### FINANCIAL AGREEMENT

#### **Patients with Insurance**

I understand that any expected payment from my insurance company is an estimate only and that I am responsible for any portion not covered by insurance. I further understand that my estimated portion must be paid in full on the day of the treatment. Any amount not covered by the insurance company is due and payable in full immediately upon notification by the insurer. It is my responsibility to verify my coverage. If payment is not completed as agreed and communication has not been made with the office, we will be forced to turn account over to a collection agency. Any/all collection charges shall be paid by me (the patient), and office shall not be held liable for any damage to patient credit rating.

#### Patients without insurance

I understand that payment is expected at time of service. I further understand that any portion not paid at this time is my responsibility. If payment is not completed as agreed and communication has not been made with the office, we will be forced to turn account over to a collection agency. All collection charges shall be paid by me (the patient), and office shall not be held liable for any damage to patient credit rating.

#### No Show fee

Effective October 1, 2019 any appointments not cancelled within 24 hours prior to appointment time will be subject to a \$50 fee.

~	Print Name:	
<b>~</b>	Patient's Signature:	
1	Date:	