thank you for selecting us.

Patient ID # _____

Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____ Sex _____ Age _____

Nickname _____ SS#/SIN _____ Birthdate _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____ Phone _____

Responsible Party

Name _____ Relationship _____

Address _____ Email _____

City _____ State/Prov. _____ Zip/P.C. _____

Home Phone _____ Cell Phone _____ Work Phone _____

SS#/SIN _____ DL # _____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information ☐ Mother ☐ Stepmother ☐ Guardian

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ Father ☐ Stepfather ☐ Guardian

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Over Please

Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # _____

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated? ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of Last Dental Visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Has your child ever had any of the following:

Acid Reflux	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Food Allergies	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No

Describe _____

Hemophilia/Abnormal Bleeding	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses When?

_____ _____

_____ _____

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

_____

Financial Arrangements

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.

☐ _____

AUTHORIZATION & RELEASE

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or Parent/Guardian if minor) Date

Dentist's Review: _____

_____

_____

_____

_____

_____

Signature of Dentist Date

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

Patient Name: _____ Date: _____

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Dr. Logan Hall.
- I may refuse to sign.
- Expiration: 3 years from initial/last signature; insurance change; patient reaches age of 18.

- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION AND INFORMATION ABOUT MY DENTAL HEALTH** VIA:

- ☐ Message on: ☐ Home Phone ☐ Cell Phone ☐ Work Phone
- ☐ Text
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ Any of the above

_____ _____

Please ***print*** your name Please ***sign*** 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: _____
- ✓ Patient's Signature: _____
- ✓ Date: _____

Logan B. Hall, DDS, PLLC