Hall Comprehensive Dentistry, LLC.

William A. Hall, Jr., DDS
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4104 Arkwright Road
Macon, GA 31210

PATIENT INFORMATION (CONFIDENTIAL)

Name: ____ **DOB**: _______________ **SSN**: ________________
(Last, First, MI)

Address: ____ City: _____________ **State**: _________ **Zip**: ________

Place of Employment: ____

Phone (Home): ________________________ (Work): _________________________ (Cell): ____________________

Email: ____

Spouse: ______________________________________ **DOB**: ____________________ **SSN**: _____________________

Place of Employment: __________________________________ Phone (Work): ______________ (Cell): ___________

HEALTH INFORMATION AND HISTORY

Emergency Contact: (If not listed above)

Name: __________________________________ Phone: ________________ Relationship: ____________________

Primary Physician:

Name: ___________________________________ Phone: _________________ City & State: ___________________

Date of last physical examination: ________________________ Date of last blood test/work: _____________________

Other Physicians & Specialists:

Name: _________________________ Specialty: _____________________ Phone: _________ City & State: _________

Name: _________________________ Specialty: _____________________ Phone: _________ City & State: _________

1. **Within the last 3 years, have you been hospitalized or had surgery?** ☐ Yes ☐ No

   If yes, please give reasons and dates: ____

2. **Have you ever been instructed to take ANY medications or take ANY special precautions before dental appointments?** ☐ Yes ☐ No

   If yes, please explain: ____

3. **Are you taking ANY drugs, medications, or treatments at this time?** ☐ Yes ☐ No

   Prescribed: ____

Over the Counter Medications: ____
Vitamins, natural or herbal preparations and/or dietary supplements: ____

4. **Are you having or have you ever had radiation or chemotherapy treatments?** ☐ Yes ☐ No

   If yes, for how long? ____________________________________ Name of facility: ___________________________________

5. **Are you taking or have you ever taken/been treated with a Bisphosphonate (Fosamax**)? ☐ Yes ☐ No
6. **Are you allergic to or have you ever experienced an unusual reaction to:**

   _____ Latex _____ Metals/Jewelry _____ Dental Anesthesia
   _____ Fluoride _____ Nitrous Oxide (laughing gas) _____ General Anesthesia

7. **Are you allergic to, or have you ever had any reaction to any of the following drugs?**
   _____ Penicillin (or related drugs) _____ Tranquilizers (Valium) _____ Tetracycline
   _____ Aspirin/Ibuprofen (Advil, Motrin, Nuprin) _____ Keflex (Cephalexin) _____ Codeine
   _____ NSAID (Celebrex, Vioxx, Anaprox) _____ Clindamycin (Cleocin) _____ Sulfa drugs
   _____ Erythromycin _____ Iodine
8. **Have you ever had an allergic reaction/unusual response to any other medications, drugs, pills, or treatments?**
   ☐ Yes ☐ No
   If yes, please list: ____

9. **Do you have, or have you had any of the following?** (PLEASE CHECK YES OR NO FOR EACH QUESTION)

	Yes	**No**
Heart valve(s) damage/Mitral Valve Prolapse	___	___
Artificial heart valve	___	___
Excessive bleeding from cut or incident	___	___
High blood pressure	___	___
Diabetes/blood sugar problems	___	___
Any artificial joint, joint surgery, or prosthesis	___	___
If **yes**, what joint or area: _______________		
When was operation done: _____________		
Hepatitis, jaundice, liver problems	___	___
Congestive heart failure	___	___
Coronary artery disease	___	___
Heart surgery	___	___
If **yes**, type & date: ___________		
Heart attack	___	___
If **yes**, date: _______________		
Rheumatic heart disease/rheumatic fever	___	___
Infective Endocarditis	___	___
Congenital heart defects	___	___
Epilepsy or seizure disorder	___	___
Kidney problems	___	___
Angina or chest pains	___	___
Anemia	___	___

	Yes	**No**
Compromised immune system (Lupus, HIV, AIDS, radiation immune problem)	___	___
Active sexually transmitted disease (STD)	___	___
Any form of cancer	___	___
Atherosclerosis	___	___
Stroke or CVA	___	___
Pacemaker	___	___
Low blood pressure	___	___
Organ transplant	___	___
Asthma	___	___
Hay fever/skin or food allergies	___	___
Sinus problems	___	___
Tuberculosis, Emphysema or lung disorder	___	___
Skin problems	___	___
Sore/wound that bleeds easily	___	___
Thyroid problem/disease	___	___
Arthritis	___	___
Glaucoma or eye disease	___	___
Any mental health issues	___	___
Been treated for any psychiatric condition	___	___
Hemophilia or bleeding disorder	___	___
Women Only:		
Are you pregnant?	___	___
If **yes**, what is your due date? ____________		
Are you presently nursing?	___	___
Are you using hormone replacement therapy?	___	___
Are you using birth control medication?	___	___

10. **Do you have any conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of?** ☐ Yes ☐ No
    If yes, please explain: ____

Financial Responsibility

A 24 HOUR NOTICE OF CANCELLATION IS APPRECIATED. We reserve the right to charge a $50 broken appointment fee if not cancelled within the 24-hour time frame. I also understand that if a check is written to this office for fees incurred is returned for insufficient funds, there will be a $25 fee applied to my account.
The undersigned agrees, whatever as agent, guarantor, or patient, that in consideration of the services being rendered to the patient, the patient hereby, individually, obligates themselves to pay the amount of the account to this office in full; unless DELINQUENT accounts will incur ALL late fees, collection fees, and legal fees. This includes a 28% commission fee to all accounts that are sent to collections.

I HAVE READ CAREFULLY, UNDERSTAND AND AGREE TO THE FINANCIAL RESPONSIBILITIES AND ASSIGNMENTS OF INSURANCE BENEFITS AS STATED ABOVE.

Signature ____________________ Date ____________________

Consent for Use and Disclosure of Health Information

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy of Practices: You will have the right to read our Notice of Privacy Practices before you decide where to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operation, and if the Use of Disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting:
Dr. Eric Hall
478-757-5455
4104 Arkwright Road
Macon, Georgia 31210

Right to revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we too in reliance on this consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, ____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your Use and Disclosure of my protected health information to carry out treatment, payment of activities, and health care options.

Signature ____________________ Date ____________________

Receipt of Notice of Privacy Practices Written Acknowledgement

I have reviewed a copy of Dr. William Hall and Dr. Eric Hall's Notice of Privacy Practices.

Signature ____________________ Date ____________________