Thomas Halliday, DDS
S. Lisa Halliday, DMD

Thank you for choosing our office as your oral health care provider. We are a patient-centered office providing high-quality comprehensive dentistry. We strive to maintain our high standards through excellent service, professionalism, compassion, efficiency, and continuing education. We are committed to the success of your treatment and forming a lasting relationship with you. Please understand that payment of your bill is considered a part of your commitment to treatment in our office.

Financial Policy

Payment is due on the day that services are rendered. For your convenience, we accept cash, checks, Visa, MasterCard, & Discover Card.

Regarding Insurance

As a complementary service we will process your dental claims with your insurance company. We will estimate the portion not covered by your insurance. Our estimates may differ from your insurance company's actual payment; therefore the amount due our office will be adjusted accordingly. The balance is your responsibility whether your insurance company pays or not. It is also your responsibility to inform us of changes in your insurance coverage.

Missed Appointments

Please help us serve you and our other patients better by keeping scheduled appointments. Missed or cancelled at the last minute appointments are then unavailable to patients anxiously awaiting dental care. If the need to cancel a scheduled appointment arises, we request **24** hours notification. Appointments cancelled with less than **24** hours' notice are subject to a **$50 fee.** Therefore, please consider your schedule carefully when scheduling appointments.

Thank you for taking the time to read and understand our financial policy. Please let us know if you have any questions.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Print first / last name: _____

Signature: _____ **Date:** _____

Thomas Halliday, DDS
S. Lisa Halliday, DMD

PATIENT INFORMATION

DIVORCED ☐ WIDOWED ☐
MINOR (Under Age 18) ☐ SINGLE ☐ MARRIED ☐

NAME _____ BIRTH DATE_____ SEX_____ PHONE(_____) _____
ADDRESS _____ CITY_____ STATE____ ZIP_____ CELL(_____) _____
SCHOOL (if full time student) _____ CITY_____ EMAIL: _____
PREVIOUS DENTIST _____ CITY_____ LAST VISIT _____
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DENTAL INFORMATION

Do your gums bleed when you brush? Yes ☐ No ☐
Are your teeth sensitive to hot or cold? Yes ☐ No ☐ Pressure Yes ☐ No ☐ Sweets Yes ☐ No ☐
Do you grind or clench your teeth? Yes ☐ No ☐
Do you have pain in your jaw joints? (TMJ) Yes ☐ No ☐
Do you have any fear of dental work? Yes ☐ No ☐
Date of last dental exam _____ What was done at that time? _____

How would you describe your current dental problem? _____

Would you like to improve the appearance of your teeth? _____

PATIENT HEALTH HISTORY

HOW WOULD YOU DESCRIBE YOUR HEALTH? _____ DATE OF LAST MEDICAL EXAM _____
NAME OF PHYSICIAN _____ CITY _____ PHONE (_____) _____

YES NO
☐ ☐ Are you having any pain or discomfort at this time?
☐ ☐ Are you now or have you been under the care of a physician within the past two years?
☐ ☐ Are you pregnant? Month: _____
☐ ☐ Are you now or have you recently been taking any medication? _____
☐ ☐ Have you experienced any ill effects or allergy to any medication? (penicillin, novocaine, codeine, aspirin) _____
☐ ☐ Have you had any major surgery or hospitalization? _____ Date_____

MEDICAL INFORMATION

Do you have or Have you had?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Disease / Attack	☐	☐	Lung Disease	☐	☐	Thyroid Problems
☐	☐	Angina Pectoris	☐	☐	Asthma	☐	☐	Kidney Trouble
☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐	Emotional Problems
☐	☐	Artificial Heart Valve	☐	☐	Liver Disease	☐	☐	Chronic Headache / Migraine
☐	☐	Heart Pacemaker	☐	☐	Hepatitis (Type A / Tybe B / Type C)	☐	☐	Arthritis
☐	☐	Rheumatic Fever	☐	☐	Drug Addiction	☐	☐	A.I.D.S.
☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐	H.I.V. Positive
☐	☐	Epilepsy	☐	☐	Prolonged Bleeding	☐	☐	Cancer
☐	☐	Fainting or Dizzy Spells	☐	☐	Diabetes	☐	☐	Chemotherapy
☐	☐	Stroke	☐	☐	Venereal Disease	☐	☐	Radiation Therapy
☐	☐	Anemia	☐	☐	Artificial Joints (Hip, Knee, etc.)	☐	☐	Allergy to Latex

☐ ☐ Do you have, or have you had, any disease, condition or problem not listed? If yes, Please List: _____

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME (Head of Household) _____ BIRTH DATE _____ RELATIONSHIP TO PATIENT _____
OCCUPATION _____ SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____
EMPLOYER _____ ADDRESS _____ PHONE (____) _____
NAME OF SPOUSE (Spouse or Head of Household) _____ BIRTH DATE _____
OCCUPATION _____ SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____
EMPLOYER _____ ADDRESS _____ PHONE (____) _____

FOR PATIENTS WITH DENTAL INSURANCE

INSURED PERSON'S NAME _____
DENTAL INSURANCE COMPANY _____ GROUP NO. _____ LOCAL NO. _____
INSURED PERSON'S NAME (If dual) _____
DENTAL INSURANCE COMPANY _____ GROUP NO. _____ LOCAL NO. _____
MEDICAL INSURANCE COMPANY _____ GROUP NO. _____ PHONE _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) and my consent to disclosure of records shall be effective until I revoke in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____

DATE _____

Health Changes: _____
Physician's Name: _____
_____
Physician's Phone: _____

Medications
_____
_____
_____
Patient Initials _____ Staff Initials _____

Date: _____

Health Changes: _____
Physician's Name: _____
_____
Physician's Phone: _____

Medications
_____
_____
_____
Patient Initials _____ Staff Initials _____

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office **(or from our website)**.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from (Name of Practice).

_____ _____

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient Print Name

Source of Authority: _____