

## Julia A. Hallisy, D.D.S., Inc.

Welcome! Thank you for choosing our office for your dental health needs. Please let us know if you need assistance when completing these forms.

### PATIENT INFORMATION

Name \_\_\_\_\_  
Last Middle First Your preferred name

Email address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please check: Married Single Domestic Partner Widowed

Driver's License # \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone numbers Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Physical address \_\_\_\_\_  
Street Apt # City State Zip

Mailing address \_\_\_\_\_  
(If different than above) Street Apt # City State Zip

Name of Spouse, Partner or Parent \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_  
Name Relationship Phone Number

**Who may we thank for referring you?** \_\_\_\_\_

### PATIENT'S DENTAL INSURANCE

Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name of Ins. Company \_\_\_\_\_ Group/Policy# \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

### SECONDARY DENTAL INSURANCE

Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name of Ins. Company \_\_\_\_\_ Group/Policy# \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_



## MEDICAL HISTORY

Name of Physician: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address/City/State \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_

**PLEASE CHECK YES OR NO FOR ALL OF THE FOLLOWING:**

Abnormal Bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies/Hay Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Angina	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hemophilia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis: Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type C <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Artificial Joint	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Artificial (prosthetic) Heart	Yes <input type="checkbox"/>	No <input type="checkbox"/>	HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Autoimmune Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Joint Replacement	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bisphosphonate Use (Actonel, Fosamax, Boniva, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood Transfusion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Breathing Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Low Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Lupus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mental Health Disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chemical Dependency	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Migraine Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chronic Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Neurological Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Congenital Heart Defect	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Osteoporosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Congestive Heart Failure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Radiation Treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cough for longer than 3 weeks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respiratory Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cough that produces blood	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes: Type I <input type="checkbox"/> Type II <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eating Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sexually Transmitted Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sickle Cell Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy or Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinus Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Excessive Thirst	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sleep Apnea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Excessive Urination	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sleep Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fainting or Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Surgical Shunt	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Swollen Glands	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heartburn or Reflux	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Infection (Endocarditis or Pericarditis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

## MEDICAL HISTORY (continued)

Do you have any health problems not listed above? Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Have you been in the hospital or had a serious illness in the last 5 years? Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Are you taking any prescription medications? Yes  No

If so, please list \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you using over-the-counter meds, herbal meds, or other supplements? Yes  No

If so, please list \_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications or substances? Please check boxes below:

Aspirin  Penicillin  Sulfa Drugs  Tetracycline  Other Antibiotics  
 Local Anesthetics  Codeine or other Narcotics  Sleeping Pills  Iodine  
 Metal  Latex  Other, please list \_\_\_\_\_

Have you ever used tobacco? Yes  No

If yes, how long, type and amount \_\_\_\_\_

Do you drink alcoholic beverages? Yes  No

How often and how much? \_\_\_\_\_

Women (please check)  Pregnant  Trying to get pregnant  Nursing  
 Using Oral Contraceptives  Hormone Replacement Therapy

To the best of my knowledge, all of the above answers are correct. If I have any changes in my health status, I will inform the dentist and the staff before my next appointment.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date

## **APPOINTMENT CANCELLATION POLICY**

We value your time and we do not "double-book" appointments. When you schedule an appointment with us, this time is reserved exclusively for you. Any change in this appointment affects many people, so we require notice of **two business days** if you are unable to keep your appointment. \*Please Note: We reserve the right to charge a fee for appointments not cancelled two business days in advance. Signing this form indicates that you understand and will comply with our cancellation policy.

## **FINANCIAL POLICY**

Payment for your dental treatment is due at the time of service, unless financial arrangements are made prior to treatment. This policy is instrumental in helping us keep dental care costs down for our patients by reducing the significant expenses associated with billing procedures. There is a \$25.00 fee for each returned check and balances over 60 days are subject to interest at the rate of 1.5% per month at our discretion.

## **DENTAL INSURANCE POLICY**

We are happy to submit your insurance claim, but please remember that your insurance policy is a contract between you and your insurance company. We do our best to estimate your co-payments and to help you utilize your insurance benefits. The patient is ultimately responsible for any amount not paid by insurance. We reserve the right to modify this policy at any time without further notice. Signing this form indicates that you understand and will comply with our financial policy.

## **AUTHORIZATION AND CONSENT**

I agree and consent to dental examination by this office. I understand that diagnostic procedures and dental treatments may be recommended and will be discussed in advance. To the best of my knowledge, I have completed this paperwork accurately and I will bring all future changes in my medical or dental history to the attention of the doctor. I understand that providing incorrect or incomplete information can be dangerous to my health. I grant permission for the office to contact me at home or work via telephone, email, or text messages. 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 or omissions that I may have made in the completion of this form.

I authorize the release of information needed to process my insurance claims. I authorize my insurance benefits to be paid directly to this dental office.

I have received a copy of and understand the Notice of Privacy Practices and I have had a copy of the Dental Materials Fact Sheet made available to me.

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Signature of Patient/Parent/Legal Guardian

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Date