

CONNELL DENTISTRY

1610 EDISON AVE. • MUSCLE SHOALS, AL 35661

(256)383-5770

Welcome to our Practice

Chart#: _____

FOR OFFICE USE ONLY

Patient Name: _____

Last

First

MI

Preferred Name

Title: _____
Mr/Ms/Mrs/etc

Gender: Male Female

Family Status: Married Single Child Other

Birth Date: _____

SS#: _____

Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

In an emergency who should be notified? Please enter Name and Phone number below: _____

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2
City State Zip Code

Patient's relationship to Insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____

Address 1

Address 2

City

State

Zip Code

Secondary Dental Insurance

Name of Insured: _____

Last

First

MI

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____

Address 1

Address 2

City

State

Zip Code

Insured's Employer Name: _____

Employer Address: _____

Address 1

Address 2

City

State

Zip Code

Patient's relationship to Insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____

Address 1

Address 2

City

State

Zip Code

Insurance Authorization:

- By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> AFIB | <input type="checkbox"/> Allergies | <input type="checkbox"/> Amoxicillin Allergy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Clindamycin Allergy | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Heart Stints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Hydrocodone Allergy | <input type="checkbox"/> Iodine | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Reflex Allergy |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Morphine Allergy | <input type="checkbox"/> NOEPI | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Smoker | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease |

- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> A smoker or smoked previously |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

If any condition or alert selected above needs further clarification, please explain below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List all medications, supplements, and/or vitamins taken within the last two years:

*By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

*By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.

Response Date: _____



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PATIENT POLICIES

Due to the growing nature of our practice, we are making some policy changes to better serve all our patients. We sincerely appreciate your continued support of our office.

*Please allow up to one (1) business day for an assistant to return messages regarding dental questions.

*To respect other patients' time, we ask that you only be seen for the dental issues for which you were scheduled. If time allows, we may be able to address additional concerns.

*If you arrive more than 20 minutes late for your appointment, you may be asked to reschedule.

*We require a 24-hour confirmation on all appointments. Any appointments that are not confirmed may be removed from the schedule.

*We require a 24-hour notice for cancellation of a scheduled appointment. Please call the office to reschedule or to remove your appointment. Failure to do so will be noted as a "no show" appointment.

*Our continued care for patients includes:

ADULTS:

- 2 prophies (cleanings) per year
- 2 doctor exams per year
- 4 bitewing x-rays every 6 months
- Fluoride application once per year
- 1 Panoramic x-ray every 3-5 years

CHILDREN:

- 2 prophies (cleanings) per year
- 2 doctor exams per year
- 2 bitewing x-rays every 6 months
- Fluoride application twice per year
- 1 Panoramic x-ray every 3-5 years (beginning at age 5)

*It is YOUR responsibility to contact your insurance company prior to the appointment to verify coverage of your visit.

*Co-pays and past due balances are due at the time of service.

By signing below, I hereby acknowledge I have read the policies listed above, and I understand my responsibilities as a patient of Dr. Nolin Connell and Dr. Keith Connell.

Patient's Printed Name

_____ Date of birth_____

Patient's Signature

_____ Date_____



CONNELL
— DENTISTRY —

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Authorization for Use or Disclosure of Protected Health Information

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. By signing this form, you consent to our use and disclosure of your protected healthcare information.

Patient Name: _____ DOB: _____
Name of parent or guardian (if different than patient): _____

1. I hereby authorize all health care providers to use and/or disclose the protected health information ("PHI") described below to me or directed below. The purpose of this request is for personal reasons.
2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial and insurance information may be disclosed to those in section 3 in order to be able to process claims with the insurance company and/or for personal reasons.
3. In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my/my dependent's PHI to the following individual(s):

4. Medical information may be used by the persons I authorize to receive this information for dental/medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and in effect until I am no longer a patient at this practice.
6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation.
7. I understand that my dental provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that payment will be collected at the time services are provided and I will be responsible for filing any claims with my dental insurance company.

Signature (Or parent/guardian): _____ Date: _____