Dr Douglas Harrell III, D.M.D

Date _____

Patient Information
Name_____ Preferred Name_____
Sex: M F **Circle one:** Single Married Widowed Divorced
Birthdate_____ **Social Security Number** _____
MailingAddress_____
Cell Phone Number _____ **Home Phone Number**_____
Email Address _____
Employed By_____

Spouse/Parent Information
Name_____ Preferred Name_____
Birthdate_____ **Social Security Number**_____
Cell Phone Number_____ **Home Phone Number**_____
Employed By_____

In case of emergency, who should be notified? _____

Dental Information

I have provided a copy of my insurance card to the front desk and it is my responsibility to let Dr. Harrell's office know if there are any changes to the initial information given. (Initial)_____

Consent to All Office Policies

My signature below indicates the following:

1. I have received, read, and understand all new patient paperwork, including but not limited to our financial, treatment, and cancellation policies. All questions that I may have regarding these policies have been asked and answered to my satisfaction.
2. I understand that it is my responsibility to update this office with any relevant changes to myself and/or child's medical history.
3. As outlined in the financial policy, I agree to be responsible for payment of all services rendered. I understand that payment is due at the time of service. I understand that if an account balance is incurred, it must be paid in full within 30 days. If payment is not received within that time frame, my account may be turned over to a collections agency, after which, my original balance and any applicable fees will be due.

_____ _____

Print your name &/or Relationship to patient Your Signature & Date

Patient Medical History Form

Physician's Name_____

Medical Conditions (Please circle all that apply):

Abnormal bleeding
Anemia
Angina Pectoris
Arthritis
Artificial Bones
Artificial Heart Valve
Asthma
Blood Transfusion
Cancer-Chemotherapy
Colitis
Congenital Heart Defect
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy
Fainting Spells
Fever Blisters
Heart Attack
Heart Surgery
Hemophilia
Hepatitis A
Hepatitis B
High Blood Pressure
HIV+/ AIDS
Kidney Problems
Liver Disease
Low Blood Disease
Mitral Valve Prolapse
Pneumocystitis
Psychiatric Problems
Radiation Problems
Rheumatic Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Thyroid Problems
Tuberculosis
Ulcers
Venereal Disease
Yellow Jaundice

Allergies (Please circle all that apply):

Aspirin
Codeine
Dental Aesthetics
Erythromycin
Latex
Metals
Penicillin
Seasonal
Tetracycline
Other:_____

Does the Patient smoke or use tobacco? Yes / No

If the patient is female, please answer the following:

Is she taking birth control pills? Yes / No
Is she pregnant? Yes/ No
is she nursing? Yes/ No

Other Medical Conditions:

_____
_____

Medications (Please list any and all that the patient is currently taking):

_____
_____
_____
_____
_____
_____
_____
_____

Self/Parent/Guardian Signature_____ Date_____

Financial Policy

Our financial policy is designed to (a) provide the absolute highest quality of dental care (b) allows us to spend more time treating your dental needs; and (c) keep treatment costs at a reasonable level.

Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan that fits your timetable and budget. We accept cash, personal checks, debit cards, Care Credit and most major credit cards. If an account balance is incurred, it must be paid in full within 30 days. If we have not received payment within that timeframe, your account may be turned over to a collections agency, after which, your original balance and any applicable fees will be due.

As a courtesy to you, we will file your claim form with your dental insurance company. The majority of claims will be filed electronically at the time of your appointment. Claims will be mailed to those insurance companies that do not accept electronic claims and will also be mailed the day of your appointment.

Please understand that this office does not have a contract with your insurance company, only you do. Although, we will file your insurance claim free of charge, we hold the patient's self/parent/guardian responsible for all charges. We will do all that we can to help you obtain information from your insurance carrier, including providing you with the appropriate insurance codes associated with your treatment plan, which may aid you in determining the reimbursable amount, as determined by your insurance carrier.

In you have any questions regarding our financial policy or need assistance with contacting your insurance company, please do not hesitate to ask a member of our front desk staff.

Permission to Release Information

From time to time, Dr. Harrell and/or staff may need to reach a patient and/or a patient's parent/guardian directly concerning an appointment, test results, pathology reports or medical/dental information. It is at the patient's and his/her parent's/guardian's discretion when and with whom we share this information. This is due to HIPAA (Health Insurance Portability and Accountability Act of 1996). Your signature on our New Patient Information Form indicates the following:

1. To whom we may release information regarding the patient and that your consent extends indefinitely, or until changed by you in writing.
2. You understand the Health Insurance Portability and Accountability Act of 1996 and, at your request; a copy of this Act was given to you.
3. You authorize the release of the patient's medical/dental information to treating or referring physicians/dentists and to insurance companies or other pertinent parties to process payments.
4. You authorize the use of fax or email to submit medical/dental information to pertinent parties.
5. You agree that a copy of this form may be used in lieu of the original.

Cancellation Policy

In our efforts to provide quality dental care to you and our other patients, we believe that keeping appointments and arriving at those appointments in a timely fashion are essential. We would appreciate it if you would call us at least 24 hours prior to your appointment to either cancel or reschedule. We understand that everyone falls ill and emergencies arise but generally speaking, if missing or breaking appointments becomes a habit we may be forced to dismiss you from our practice. Additionally, not providing adequate notice of your inability to keep an appointment is expensive for this practice to endure. Regrettably, this is a cost that we would unfairly be forced to transfer to the rest of our patients via increased fees for service. As such, if you do not call our office to let us know that you are unable to keep your appointment and simply do not show up, we will have to enforce a "broken appointment fee."