Dr. Kimra Hall & Associates
Family Dentistry

Cañon City CO. 719.276.0128

Patient Registration Form

Thank you for selecting our dental health team! To help us meet all you dental health care needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN _____

Marital Status: *(Check one) :* S ☐ M ☐ D ☐ W ☐ Gender: *(Check one) :* M ☐ F ☐

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Responsible Party Name: _____ SSN: _____

Person Responsible for the Account: Patient ☐ Spouse ☐ Parent / Guardian ☐ (Specify Other): _____

Primary Dental Insurance Information:

Name of insured: _____ Relationship: _____

Insured's Date of Birth: _____ SSN _____

Dental Insurance Company: _____ Insurance Phone: _____

Insurance CO. Address: _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Initial one of the following: _____ *I do not have Colorado Medicaid or* _____ *I do have Colorado Medicaid*

I acknowledge that I am expected to pay the fee's I incur at the time of service. If payment is not made as agreed, I will be responsible for any and all interest (at 2% per month or 24% per annum, compounded monthly), reasonable attorney fees (including pre-suit fees incurred), costs of collection and court costs incurred in an effort to enforce this agreement.

As a courtesy, we will submit dental insurance claims and accept no responsibility for the amount, length, or scope of my provider's coverage. Should situations arise concerning my dental coverage, I understand it is my responsibility to contact my insurance company. If Dr. Kimra Hall & Assocs. is not a preferred provider for my insurance, I understand I may be responsible for payment in full the day of my appointment; (In this case I will be directly reimbursed by my insurance company). Insurance coverage estimates provided to me by Dr. Kimra Hall & Assocs. are based on amounts reported by my insurance company at the time coverage information was requested and are subject to change.

My signature below indicates I understand and agree to all the above.

Signature: _____ Date: _____

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Patient Medical and Dental History

Patient Name: _____ Date: _____

Although dental personnel primarily treat dental conditions, your mouth is part of your entire body. Health problems you may have or medications you may be taking could have an effect on the dentistry you will receive.

Dental History:

Primary reason for this appointment: ☐ Exam ☐ Emergency ☐ Consultation

Do you have a specific dental problem? ---------- *Please Explain:* _____

Do you think you have active decay or gum disease? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Do you want to keep your remaining teeth? ☐ Yes ☐ No

Do you have clicking, popping, or discomfort? ☐ Yes ☐ No

Preferred Dentist or Provider: _____

Medical History:

Are you under the care of a physician? ☐ Yes ☐ No *If yes, please explain* _____

Have you ever been hospitalized or had major operation? ☐ Yes ☐ No *If yes, please explain* _____

Are you taking any medications or pills, or drugs? Please List: _____

Have you received treatment for osteoporosis? ☐ Yes ☐ No *If yes, please list* _____

Do you use tobacco? ☐ Yes ☐ No *If yes, (check one)* ☐ Smoke ☐ Chew ☐ Vape

Are you allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics

Other: (Please be specific) _____

Women: (Are you):

☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives

Do you have, or have you had, any of the following:

☐ Angina	☐ Hemophilia	☐ Alzheimer's	☐ Kidney Problems
☐ Heart Attack	☐ Anemia	☐ Glaucoma	☐ Renal Dialysis
☐ Heart Murmur	☐ Scarlet Fever	☐ Arthritis/Gout	☐ Cancer
☐ Mitral Valve Prolaspe	☐ Asthma	☐ Artificial Joint	☐ Chemotherapy
☐ Congenital Heart Disorder	☐ Easily Winded	☐ Swelling of The Limbs	☐ Radiation Treatments
☐ Pace Maker	☐ Emphysema	☐ Cortisone Medication	☐ Leukemia
☐ Chest Pains	☐ Lung Disease	☐ Ulcers	☐ Liver Disease
☐ Irregular Heartbeat	☐ Tuberculosis	☐ Frequent Diarrhea	☐ Hepatitis A, B, or C
☐ Artifical Heart Valve	☐ Hay Fever	☐ Gastric Reflux Diesease	☐ Drug Addiction
☐ High Blood Pressure	☐ Sinus Trouble	☐ Recent Weight Loss	☐ AIDS/HIV
☐ Low Blood Pressure	☐ Frequent Headaches	☐ Eating Disorder	☐ Venereal Disease
☐ Excessive Bleeding	☐ Stroke	☐ Diabetes	☐ Shingles
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ Hypoglycemia	☐ Psychiatric Care
☐ Rheumatic Fever	☐ Epilepsy/Seizures	☐ Excessive Thirst	

Have you had any other illness not listed above? ☐ Yes ☐ No If yes, please list: _____

Emergency Contact: _____ Phone Number _____

Emergency Contact: _____ Phone Number _____

To the best of my knowledge, I have accurately answered the questions on this form. I understand providing incorrect or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform Dr. Kimra Hall & Associates of any changes in medical status in a timely manner.

Signature: _____ Date: _____

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Privacy Practices Acknowledgement/HIPAA

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. On the laminated sheet attached to the clipboard, we have provided a description of our policies regarding the limited disclosure we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully before signing this 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. This includes, but is not limited to, submission of insurance claims and consultation with dental specialists (endodontists, oral surgeons, periodontists, etc.) if necessary.

I acknowledge that I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to Dr. Kimra Hall & Associates to the use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Missed or Failed Appointment Policy

Dr. Kimra Hall & Associates take great pride in offering quality, comprehensive care for every patient. We are careful in scheduling each appointment so that each patient receives their recommended treatment in a reasonable amount of time while still accommodating individual needs. In order to consistently provide this type of care, it is important for our patients to be on time for their scheduled appointments so we can keep our schedule running smoothly.

Based upon this practice philosophy, Dr. Kimra Hall & Associates has adopted a **policy regarding no-show** or **last minute cancellations**. When an appointment is canceled with **less than 24 hours notice** or if the appointment is not honored, you will be charged a **$50 an hour missed appointment fee**. You will be required to pay this fee prior to scheduling future appointments.

Continuous failed appointments will result in dismissal from the practice.

If you are dismissed we will continue to provide emergency services for 40 days to allow you to find another dentist.

If you move or change phone numbers without informing our office, and we are unable to contact you in order to confirm an appointment. Your appointment time will not be held for you.

I acknowledge that I have had full opportunity to read and inquire about the "Missed or Failed Appointment Policy" and HIPAA Acknowledgement..

Patient Name: _____ Birth Date: _____

Signature: _____ Date: _____

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DENTAL TREATMENT CONSENT FORM

For your convenience, we make available this **generalized dental consent form** for your review and signature. Please do not hesitate to ask our dental staff any questions you may have. For more detailed information, please visit our website, www.drkimrahall.com

1. DRUGS AND MEDICATIONS
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

2. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.

3. REMOVAL OF TEETH
I understand that If teeth are savable/restorable, the alternatives to removal of teeth are root canal therapy, crowns, and periodontal surgery, etc. I also understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

4. CROWNS, BRIDGES AND CAPS
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

5. DENTURES, COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances include looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

6. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

7. PERIODONTAL LOSS (TISSUE & BONE)
I understand that serious gum problems can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

8. LOCAL ANESTHESIA
I understand that Anesthetic is utilized to numb tissue for dental surgical procedures. Some patients may experience temporary increased heart rate, allergy, soreness, nerve or blood vessel bruising, tingling, or numbness which may very infrequently be indefinite, and trauma after the procedure from being numb.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Signature of Patient _____ Date _____

Signature of Patient, Guardian or Representative _____ Date _____

Signature of Patient, Guardian or Representative _____ Date _____

Patient Scheduling Policies

Please read carefully, initial on the line provided for each one and sign and date the bottom.

Initials

The following policies apply to all patients:

_____ I acknowledge that I am expected to pay the fees I incurred at the time of service. In the event my account is turned over to collections for failure to pay I will be held responsible for all finance charges, collection costs, attorney's fee, and any other cost incurred to enforce the collection of any outstanding amount.

_____ I acknowledge Dr. Kimra Hall & Associate's ***No-Show / Late Cancellation Policy***:
* If I cancel an appointment ***with less than 24 hour business hours notice or the appointment is missed, I will be charged $50 /hour for-which I was scheduled*** and will be required to pay this fee before another appointment will be secured.
Missed appointments could result in dismissal as a patient from this practice. If you are 15 minutes late for your appointment it will be considered a missed appointment and rescheduled one time.

_____ I acknowledge that I will be required to pay **half down for any 2 hour or more procedure**s at time of scheduling.

_____ I acknowledge that it is my responsibility to ensure the office has my current contact information so that confirmation can be made for my upcoming appointments.

_____ I acknowledge that if my appointment cannot be confirmed it may not be reserved.

The following policies apply to patients with dental insurance:

_____ I acknowledge that I am responsible for all insurance co-payments on the day of service including services I authorize to be preformed that are not covered by my insurance provider. Insurance coverage estimates provided to me by Dr. Kimra Hall & Associates are based on amounts reported by my insurance company at the time coverage information was requested and are subject to change.

_____ I acknowledge that should a situation arise concerning my dental coverage, I understand it is my responsibility to contact my insurance company.

_____ I acknowledge that if Dr. Kimra Hall & Associates is not a preferred provider for my insurance, I will be responsible for payment in full the day of my appointment.

_____
Printed Name of Patient

_____ _____
Signature of Patient Date