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Dr. Kimra Hall & Associates
Family Dentistry

Cañon City CO. 719.276.0128 & Pueblo West CO. 719.647.9433

Patient Registration Form

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your 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 _____ Driver's license Number: _____

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: _____ DL#: _____

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: _____

Secondary Dental Coverage: (if applicable)

Do you have secondary dental insurance? Yes ☐ No ☐

If yes, please provide information on your coverage. We will be happy to file your secondary claim for you. However, you are responsible for all co-payments before your secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Name of insured: _____ Relationship: _____

Insured's Date of Birth: _____ SSN _____

Dental Insurance Company: _____ Insurance Phone: _____

Insurance CO. Address: _____

Subscriber Number: _____ Group Number: _____

Employer Name: _____

Whom may we thank for referring you to our office? ***Please let Us know*** _____ Other: _____

Children under the age of 16 must be accompanied by an adult (guardian). 16 to 18 year olds must have guardian's written consent for treatment.

I acknowledge that I am responsible for all insurance co-payments on the day of service including services preformed that are not covered by my insurance provider. **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**. Financial Responsibility: I agree to pay all finance charges, collection costs, attorney's fees, and any other costs incurred to enforce the collection of any outstanding amount.

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

Signature: _____ Please Print Then Sign _____ Date: _____

PNP91211©

Child's Medical & Dental History

Childs name: _____ Date of Birth: _____ Gender: ☐ Female ☐ Male

What is the main reason you brought your child to us today? _____

Has your child ever had any of the following?		Comments
Heart Murmur	☐ Yes ☐ No	
Congenital heart disease	☐ Yes ☐ No	
Asthma, Cystic Fibrosis, Resiratory Disease	☐ Yes ☐ No	
Diabetes, Thyroid, Glandular, or other Endocrine Disease	☐ Yes ☐ No	
Liver Disease / Hepatitis / Laundice	☐ Yes ☐ No	
Kidney Disease	☐ Yes ☐ No	
Skin, Bone, Muscle, or Joint Disease	☐ Yes ☐ No	
Seizures / Convulsions / Loss of Consciousness	☐ Yes ☐ No	
Cerebral Palsy or Neurological Disease	☐ Yes ☐ No	
Sexually Transmitted Disease or HIV	☐ Yes ☐ No	
Anemia, Hemophilia, other Blood Disorders	☐ Yes ☐ No	
Sickle Cell Disease or Trait	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Speech disorder	☐ Yes ☐ No	
Hearing disorder	☐ Yes ☐ No	
Sight or eye disorder	☐ Yes ☐ No	
Frequent Headaches	☐ Yes ☐ No	
Mental, Emotional, or Developmental delays	☐ Yes ☐ No	
Autism, ADHA, Genetic Disorder / Syndrome (please note)	☐ Yes ☐ No	
Frequent infections	☐ Yes ☐ No	
Has your child ever received blood / blood products?	☐ Yes ☐ No	
Has your child ever been hospitalized?	☐ Yes ☐ No	
Has your child ever been seriously ill?	☐ Yes ☐ No	
Has your child ever had any significant injury?	☐ Yes ☐ No	
Has your child ever had surgery?	☐ Yes ☐ No	
Which medicines does your child take at this time?	☐ Yes ☐ No	
Is your child allergic		
..... to any medicines?	☐ Yes ☐ No	please list:
..... to any foods, environment pollutants, animal?	☐ Yes ☐ No	please list:

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Is there any other problem, disease, or medical condition that we should know about in order to care for your child?

☐ Yes ☐ No Please list: _____

Is there any other problem, disease, or medical Who is your child's Primary Physician's Group?

Name: _____ In: _____ Phone: _____

Has your child ever had any of the following?		Comments
Pain in the teeth	☐ Yes ☐ No	
Swelling of the mouth and face	☐ Yes ☐ No	
Injury to the face or teeth	☐ Yes ☐ No	
A bad dental experience	☐ Yes ☐ No	
Does your water have fluoride	☐ Yes ☐ No	
Does your child thumb suck or other oral habit	☐ Yes ☐ No	
Does your child have any other dental condition	☐ Yes ☐ No	

Which of the following categories best describes your child's learning abilities? ☐ Delayed ☐ Normal ☐ Advanced

How do you think your child will cooperate for this appointment? ☐ Well-behaved ☐ Unsure ☐ Uncooperative

_____ _____ _____

Parent / Guardian Signature Date Reviewed by DDS, DMD

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Privacy Practices Acknowledgement/HIIPA

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.

Patient Name: _____ Birth Date: _____

Signature: _____ Date: _____

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 cancelled with less than 24 hours notice** or if the appointment is not honored, **you will be charged a $40 missed appointment fee**. You will be required to pay this fee prior to rescheduling the appointment. If three appointments are missed, you will be dismissed from the practice. We will continue to provide emergency services for 30 days to allow you to find another dentist.

If you move or change phone numbers without informing our office, we may be unable to contact you in order to confirm an appointment. In such an instance, your appointment time will not be held for you.
I acknowledge that I have had full opportunity to read the "Missed or Failed Appointment Policy".

Signature above on this form.

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MEDICAID ONLY

Name: _____ Primary Number: _____

Date _____ Secondary Number: _____

Dear Parent:

Currently there is an overwhelming demand for medicaid dental services in Fremont County, Colorado. At our office we are pleased to accept Medicaid patients. However, due to the limited space in our schedule, and our desire to help as many Medicaid patients as possible it is very important that your child is present for their scheduled appointments. **If your appointment cannot be confirmed** by either phone number you have provided above, your child's **appointment time will not be reserved.**

Our policy is that we will schedule your child / children one time. If your child misses their appointment we will not reschedule unless a written physician's note is presented explaining that your child was too ill to keep this appointment. If you child is scheduled for treatment at the hospital and you fail to keep this appointment, we will not schedule your child again.

We ask that you take great care scheduling only appointments you are sure that you can keep. Please sign and date this form to insure that you understand this policy.

Signature: _____ Date: _____

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