

Welcome To Boulevard Smiles

by Dr. Joe F. Hair, Jr.

Name (last, first, middle): _____

Home Address: _____

Preferred Name: _____ SS#: _____ D.O.B: _____

Home Phone: _____ Cell Phone: _____ Sex: M ___ F ___

Work Phone: _____ E-Mail: _____

Person Financially Responsible for the Account: _____

In case of emergency, whom should we contact? Name: _____ Phone #: _____

Whom may we thank for this referral? _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Address: _____

Home Phone: _____ SS#: _____ DOB: _____

Employer: _____ Address: _____

Plan Name: _____ Group: _____

Insurance Co: _____ Individual Yearly Deduct: _____

Address: _____ Family Yearly Deduct: _____

SECONDARY DENTAL INSURANCE

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Address: _____

Home Phone: _____ SS#: _____ DOB: _____

Employer: _____ Address: _____

Plan Name: _____ Group: _____

Insurance Co: _____ Individual Yearly Deduct: _____

Address: _____ Family Yearly Deduct: _____

Have you been under the care of a medical doctor during the past two years? YES NO

If so, for what? _____

Physician's Name: _____ Phone #: _____

Are you taking any medication now, including regular dosages of aspirin? YES NO

If so, please list name and dosage: _____

Are you aware of having an allergic reaction to any medication or substance? YES NO

If so, please list: _____

****Indicate which of the following you have had, or have at present, Circle “yes” or “no” to each item.****

Heart Concerns	Yes	No		Headaches	Yes	No
Congenital Heart Disease	Yes	No		Jaw Pain	Yes	No
Heart Murmur	Yes	No		Jaw Popping	Yes	No
Rheumatic Fever	Yes	No		Limited Jaw Opening	Yes	No
High Blood Pressure	Yes	No		Congested Ears	Yes	No
Mitral Valve Prolapse	Yes	No		Dizziness	Yes	No
Artificial Heart Valve	Yes	No		ringing Ears	Yes	No
Pacemaker	Yes	No		Loose Teeth	Yes	No
Stroke	Yes	No		Posture Problems	Yes	No
Asthma	Yes	No		Clenching	Yes	No
Liver Disease	Yes	No		Grinding	Yes	No
Latex Sensitivity	Yes	No		Facial Pain	Yes	No
Artificial Joints	Yes	No		Sensitive Teeth	Yes	No
Kidney Trouble	Yes	No		Neck Pain	Yes	No
Radiation/Chemotherapy	Yes	No		Bell’s Palsy	Yes	No
Epilepsy/Seizures	Yes	No		Difficulty Swallowing	Yes	No
Diabetes	Yes	No		Difficulty Chewing	Yes	No
Hepatitis	Yes	No		Trigeminal Neuralgia	Yes	No
AIDS/HIV	Yes	No		Tingling in arms/fingers	Yes	No
Sickle Cell Disease	Yes	No		Insomnia/frequent waking	Yes	No
Psychiatric/Psychological	Yes	No				
Does floss shred when you use it	Yes	No		Does food pack/catch between your teeth?	Yes	No
Do you smoke/chew tobacco?	Yes	No		Does your breath concern you?	Yes	No

Do you or have you had any disease, condition, or problem not listed? _____

Women: Are you pregnant? _____ Nursing? _____ Taking Birth Control Pills _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health and/or medication.

Patient’s Signature: _____ Date: _____

Our office is like no other dental office. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. Some of these questions may raise issues you have never considered. Please tell us what best expresses what you want:

- What brings you to see us? _____
- How long has this been going on? _____
- Do you want us to limit your treatment to this chief complaint? _____
- Do you want a general examination? _____
- Do you want a cosmetic evaluation? _____
- What would you like to change about your smile? _____
- Do you want a functional evaluation for bite problems? _____
- How healthy do you want us to get your mouth? (Circle One)
The best it can be Average Just fix the current problem
- At what point do you want us to initiate treatment? (Circle One)
When something isn't ideal When something is worsening When it hurts or breaks
- Have you had bad dental experiences you want us to know about? _____
- Why did you leave you last dental office? _____
- How did you hear about our office? _____
- Did someone refer you to us? _____
- What do you expect from our office? _____
- Has fear ever been a factor in getting your dental work done? _____
- Are you interested in sedation dentistry? _____
- Has time been a factor in getting your dental work done? _____
- Would you like to get treatment done in the fewest number of treatments? _____
- Is there any day you can't come for appointments? _____
- Has the cost of dental treatment been a concern for you? _____
- Would you like to know what financing options are available? _____
- Will anyone be involved in helping you decide about treatment recommendations? _____
- Is there any additional information you would like us to know? _____

Joe F. Hair, Jr., D.M.D., F.A.G.D.

A Fellow in the Academy of General Dentistry

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(770) 949-1005
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General Dentistry
Orthodontics

"...where smiles are made to last."

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

I consent to the use or disclosure of my protected health information by Dr. Joe Hair for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by Dr. Hair may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Hair is not required to agree to the restrictions that I may request. However, if he agrees to a restriction that I request, the restriction is binding on him. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Hair has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Dr. Joe Hair and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Joe Hair. The Notice of Privacy Practices for Dr. Joe Hair is also posted in the waiting room of Boulevard Smiles at 6842 Douglas Blvd. Douglasville, GA 30135. This Notice of Privacy Practices also describes my rights and duties of Dr. Joe Hair with respect to my protected health information.

Dr. Hair reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Dr. Hair and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority

Our Financial Agreement

Thank you for choosing us as your family dental provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Agreement, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information and Health History Forms before seeing Dr. Hair.

- **FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. FOR OUR PATIENTS THAT DO HAVE DENTAL INSURANCE, WE WILL GLADLY ALLOW ASSIGNMENT OF DENTAL BENEFITS TO OUR OFFICE.**
- **WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, CARE CREDIT & CAPITAL ONE FINANCIAL.**
- **A \$25.00 CHARGE WILL BE ASSESSED FOR RETURNED CHECKS.**

Regarding Insurance and Workman's Compensation

To avoid a misunderstanding regarding dental insurance and workman's compensation, we want to say that all of our fees are billed to you, our patient, and you are responsible for those fees. If you wish, we will allow you to assign payment of your primary third party benefits to our office as partial payment for those services. We will provide you with the necessary paperwork so that you may be reimbursed by any secondary coverage. We will ask that you pay an amount predetermined by our office prior to treatment, and we will ask that you leave a credit card to cover any balance remaining following insurance payment.

Usual and Customary Fees

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult and the parents (or guardians) accompanying a minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized.

Thank you for understanding our Financial Agreement. Please let us know if you have any concerns.

I have read the Financial Agreement. I understand and agree to the Financial Agreement.

X _____ **Date** _____

Boulevard Smiles by Dr. Joe F. Hair, Jr.
6842 Douglas Blvd. Ste K, Douglasville, GA 30135 (770) 949-1005

Boulevard Smiles by Dr. Joe F. Hair

...where smiles are made to last."

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This and the following page are required only for those guests with dental insurance who wish to assign payment of their third party benefits to Boulevard Smiles.

Assignment of Dental Benefits

I assign Joe F. Hair DMD all payments for dental services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by assigned insurance. I authorize Joe F. Hair DMD release of any information to Insurance Carriers, Physicians, or Hospitals concerning treatment. I authorize my Physician, Hospital or Medical Care Facility to provide all information on medical history and treatment to Joe F. Hair and I authorize photocopies of this form to be as valid as the original. I have read and understand the above and give Joe F. Hair DMD permission to treat me (my child).

Printed Name

Signature

Date

Boulevard Smiles by Dr. Joe F. Hair

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In consideration of Joe F Hair, Jr, DMD, PA's allowing me to assign payment of my dental benefits to his office, I agree to the following:

1. I will pay the portion requested at the time of scheduling or before the appointment as requested.
2. I will be responsible for making sure that my insurance pays. I understand that Dr Hair's office will help me in any way they can, but they are not responsible for collecting from my insurance company.
3. I will provide a credit card # (below), and authorize Joe F Hair, Jr, DMD, PA to charge any balance remaining following insurance payment or after 30 days from treatment date.

Name of Insured: _____

Signature of Insured: _____ Date: _____

Birth date of Insured: _____

Cardholder's signature indicates that cardholder agrees with terms above*

Card #: _____ Exp: _____ Security: _____ Card Type: MC / Visa

Name as it appears on Card: _____

Signature: _____

Other Dependents Covered

Name

Birthdate
