Jennifer H. Drummond, DMD
GENERAL DENTISTRY

jenniferdrummonddmd@gmail.com
smilehsv.com 256.883.8358

500 Whitesport Drive - Suite 1, Huntsville, Alabama 35801

PATIENT INFORMATION

Chart# _____
FOR OFFICE USE ONLY

Patient Name _____
Last First MI Preferred Name

Title _____ Gender ◯ Male ◯ Female Family Status ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc.

Birth Date _____ SSN# _____ Prev. Visit _____

Email Address _____ Best Time To Call _____

Phone _____
Home Mobile Work Ext Fax Other

Address _____
Address 1 Address 2

_____
City State Zip Code

Patient's Employer _____

Whom may we thank for referring you to our practice? _____

PERSON RESPONSIBLE FOR BILL

Please enter information for the person financially responsible for the account.

Please Indicate Responsible Party

◯ If the patient is financially responsible for this account, skip this section and continue to the next section.

◯ Other - Please fill out information below

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither - not applicable

Name _____
Last First MI Preferred Name

Title _____ Gender ◯ Male ◯ Female Family Status ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc.

Birth Date _____ SSN# _____ DL# _____

Email Address _____ Best Time To Call _____

Phone _____
Home Mobile Work Ext Fax Other

Address _____
Address 1 Address 2

_____
City State Zip Code

Employer _____

PRIMARY DENTAL INSURANCE

Name Of Policy Holder _____

Date Of Birth _____

Policy Holder's SSN For Insurance Purposes _____

Policy Holder's Employer

_____

_____

Insurance Company Name

_____

_____

ID / Policy Number _____

Group Number _____

Insurance Authorization

☐ By checking this box:
I authorize my primary and/or secondary insurance company to pay the dentist all insurance benefits 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.

_____

SECONDARY DENTAL INSURANCE (If Applicable)

Name Of Policy Holder _____

Date Of Birth _____

Policy Holder's SSN For Insurance Purposes _____

Policy Holder's Employer

_____

_____

Insurance Company Name

_____

_____

ID / Policy Number _____

Group Number _____

_____

DENTAL INFORMATION

What Is The Reason For Your Appointment?

_____

_____

Previous Dentist Name And Phone Number _____

Date Of Most Recent Dental Exam And Dental X-rays _____

Check All That Apply

- ☐ Had complications from past dental treatment
- ☐ Had or have braces (orthodontic treatment)
- ☐ Food gets trapped between any teeth
- ☐ Have difficulty chewing
- ☐ Gums bleed when brushing or flossing
- ☐ Had an unpleasant taste or odor in your mouth
- ☐ Had trouble getting numb
- ☐ Have dry mouth
- ☐ Have whitened or bleached your teeth
- ☐ Clench or grind your teeth
- ☐ Have been treated for gum disease
- ☐ Have or had a burning sensation in your mouth
- ☐ Had any reactions to local anesthetic
- ☐ Teeth are sensitive to hot, cold, biting or sweets
- ☐ Have popping and/or clicking of your jaw joint
- ☐ Wear or have worn a bite appliance
- ☐ Have or had gum recession
- ☐ Snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

FINANCIAL POLICY

If applicable, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances that are not paid within 30 days may be billed to you. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

PAYMENTS OVER $250 MADE BY CREDIT OR DEBIT CARD WILL HAVE A 3% ADDITIONAL FEE.

There will be a minimum fee of $50 for any check returned as Non-Sufficent Funds (NSF).
Patient balances that go unpaid for 60 or more days may be referred to a collection company or attorney. In the event this occurs, you will be liable for the collection cost.
I understand that and agree I will be responsible for payment of all services rendered on my behalf.
I understand that I will be liable for the collection cost of 20% or a minimum of $50.

☐ By checking this box, I understand the above information and agree with its contents.

SIGNATURE: _____

CONSENT TO TREAT

I give permission for Jennifer H. Drummond, DMD to give me medical treatment.
I allow Jennifer H. Drummond, DMD to file for insurance benefits to pay for the care I receive.
I understand that:
Jennifer H. Drummond, DMD will have to send my medical record information to my insurance company.
I must pay my share of the costs.
I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
I understand:
I have the right to refuse any procedure or treatment.
I have the right to discuss all medical treatments with my clinician.

☐ By checking this box, I understand the above information and agree with its contents,

SIGNATURE: _____

CANCELLATION POLICY

Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our electronic confirmation contact. We reserve the right to cancel any unconfirmed appointment as this time could be given to another patient in need.

FAILURE TO KEEP YOUR CONFIRMED APPOINTMENT WILL RESULT IN A MISSED APPOINTMENT FEE OF $50

☐ By checking this box, I understand the above information and agree with its contents.

SIGNATURE: _____

HIPAA ACKNOWLEDGEMENT

- I understand that at any time, this authorization may be revoked or cancelled, except (a) to the extent informaiton has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider.

- I understand that once the information leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your informaiton may no longer be protected by HIPAA. If the person or entity receiving this informaiton is not a health care provider or health plan covered by federal privacy regulations, the information descibed above may be disclosed to other individuals or institutions and no longer protected by these regulations.

- I understand that the maximum disclosure accounting period is six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal respresentative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care.

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient _____

_____

☐ By checking this box, I understand the above information and agree with its contents.

Name of person filling out this form _____

SIGNATURE: _____

Relationship to Patient ☐ Self ☐ Parent ☐ Step-Parent ☐ Grandparent ☐ Legal Guardian ☐ Other

RESPONSE DATE: _____

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MEDICAL HISTORY

Patient name _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking this box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ PRE-MED
- ☐ Allergy - Anesthetics
- ☐ Allergy - Bactin
- ☐ Allergy - Epinephrine
- ☐ Allergy - Iodine
- ☐ Allergy - Lortab
- ☐ Allergy - NSAIDs
- ☐ Allergy - Phenergan
- ☐ Allergy - Sulfa Drugs
- ☐ Allergy - Xylocaine
- ☐ Arthritis
- ☐ Betadine
- ☐ Bruxism
- ☐ Chemo/Radiation
- ☐ Decongestants
- ☐ Drug Addiction
- ☐ Frequent Cough
- ☐ Head Injuries
- ☐ Heart Pacemaker
- ☐ Herpes
- ☐ Hypoglycemic
- ☐ Kidney Transplant
- ☐ Mitral Valve Prolapse
- ☐ Other - See Note
- ☐ Pre Diabetic
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Triple Bypass
- ☐ Vaccinated for HPV
- ☐ A-Fib
- ☐ Allergy - Asprin
- ☐ Allergy - Ceclor
- ☐ Allergy - Erythromycin
- ☐ Allergy - Keflex
- ☐ Allergy - Macrobid
- ☐ Allergy - Other
- ☐ Allergy - Seasonal
- ☐ Allergy - Tetracycline
- ☐ Anaphylaxis
- ☐ Artificial Joints
- ☐ Blood Clots
- ☐ C Diff
- ☐ Chron's disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gastric Bypass / Sleeve
- ☐ Heart Bypass
- ☐ Heart Stent
- ☐ High Blood Pressure
- ☐ Intestinal Disease
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Valve Replacement
- ☐ Allergy - Acetaminophen
- ☐ Allergy - Augmentin
- ☐ Allergy - Clindamycin
- ☐ Allergy - Hand Sanitizer
- ☐ Allergy - Latex
- ☐ Allergy - Metformin
- ☐ Allergy - Penicillin
- ☐ Allergy - Statins
- ☐ Allergy - Toradol
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Colitis
- ☐ Dizziness / Fainting
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Joint Replacement
- ☐ Lung Disease
- ☐ Osteonecrosis
- ☐ Peridex
- ☐ Rheumatic Fever
- ☐ STD / HPV
- ☐ TMJ
- ☐ Tumors
- ☐ Vape
- ☐ Allergy - Amoxicillin
- ☐ Allergy - Azithromycin
- ☐ Allergy - Codeine
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Levoquin
- ☐ Allergy - Nickel
- ☐ Allergy - Percocet
- ☐ Allergy - Sudafed
- ☐ Allergy - Vancomycin
- ☐ Angina
- ☐ Auto Immune Disease
- ☐ Brain Shunt
- ☐ Cephalosporin
- ☐ Coronary Artery Disease
- ☐ Drink Alcohol
- ☐ Extreme Obesity
- ☐ Gout
- ☐ Heart Murmur
- ☐ Hepatitis B
- ☐ HIV
- ☐ Kidney Disease
- ☐ Menieres Disease
- ☐ Osteoporosis
- ☐ Persistent Hoarseness
- ☐ Shingles
- ☐ Stomach Problems
- ☐ Tonsilitis
- ☐ Ulcers
- ☐ Watchman

☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant).

MEDICAL HISTORY

Allergies not listed:

Have you had a joint or valve replacement? If so, you will need to pre-medicate. Let the office know prior to your visit.

◯ YES ◯ NO

Do you smoke or use tobacco? ◯ YES ◯ NO

Name of your Physician and Phone Number

Preferred Pharmacy and Phone Number

In an emergency who should be notified? Please enter name and phone number below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin or vitamin supplements?

◯ YES ◯ NO

Please list any medications you are currently taking, one medication per line:

Have you taken or are you taking any bisphosphonate drug used to treat osteoporosis or paget's disease? Examples: fosamax, actonel, boniva, reclast, didronel, zometa, prolia etc. If yes, please enter the drug in the medications list above.

◯ YES ◯ NO

Desribe any current medical treatment, recent hospitalizations and recent or impending surgery.

☐ By checking this box, I understand that I have reviewed all questions/alerts on this questionaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any further changes.

SIGNATURE: RESPONSE DATE: