The Dental Health Center
Randall G. Palmore, DMD, FAGD

THE DENTAL HEALTH CENTER

(205) 681-0459

Welcome to our practice

Welcome to the office of Dr. Randall Palmore and his team. We are pleased that you have chosen our office for your dental care. Our goal is to deliver to you treatment in a pleasant and professional manner, and provide you with the highest quality of dentistry possible. You will find that our approach to dental care aims for excellent dental health, comfort and satisfied patients. Our office is equipped with state of the art equipment, computers and instrumentation. This letter is our way of introducing ourselves to you in order that you can better understand our philosophy and approach to dental care, and answer any questions that you might have.

About our office

We have been serving our patients over the past twenty years in the Pinson area. We feel that you will be pleased and satisfied with the friendliness of the staff as well as the gentle and thorough approach of both Dr. Palmore and his team.

Dr. Palmore and his team place great emphasis in dental health including the areas of gum health, jaw posture, occlusion, muscle balance, teeth appearance and nutrition, realizing that a conservative and preventative approach is of utmost importance for long term comfort and optimal health of the whole body.

We feel proud and honored that we can service this community as well as you in improving your dental health, smile and any dental needs that are of concern to you. Our desire is to provide a quality and pleasant dental experience for each of your visits.

Your first visit

Dental care and treatment needs vary from patient to patient. On your first visit, we will review your medical and dental history and perform a comprehensive examination of your teeth, gums, bone and jaw joints; as well as a cancer-screening exam.

Necessary records will be taken of all the teeth in order for the Doctor to best give a full and proper assessment. We will then discuss potential treatment options and fees, and answer any questions you may have.

THE DENTAL HEALTH CENTER
DR. RANDALL PALMORE, D.M.D., F.A.G.D.

We are pleased to welcome you to our dental practice.
Please take a few minutes to fill out this patient registration from as completely as you can. If you have any questions we'll be glad to assist you. We look forward to working with you to maintain your dental health.

Name: Dr./Mr./Mrs./Miss _____

Preferred Name _____ Email Address _____

Sex _____ Birth Date _____ Marital Status _____

Home Phone _____ Wk Phone _____ Cell Phone _____

Preferred phone number to be used during the day _____

Street Address _____

City _____ State _____ Zip Code _____

Occupation _____ Employer _____

Social Security # _____ Driver's License _____

Spouse's Name _____ Birth Date _____ Wk # _____

Occupation _____ Spouse's Employer _____

Social Security # _____ Driver's License _____

Other family members that are patients of this office _____

Name on family account _____

PLEASE PRESENT ANY APPLICABLE DENTAL INSURANCE CARD TO BE DUPLICATED FOR OUR RECORDS

I agree that all charges for services and/or materials are due and payable at the time of service. Should the account become delinquent and require the services of a collection agency or an attorney, I will pay all collection fees, attorney fees and all court costs for said collection. I have completed the dental registration form in all accuracy to the best of my knowledge.

Signature Date

Whom may we thank for referring you? _____

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Patient Name _____ Date _____

DENTAL HISTORY

Are you having pain or discomfort at this time? __Yes __No Reason for visit?

_____

Do you have a specific dental problem? __Yes __No

Describe:_____

Have you ever had any complications following dental treatment? __Yes __No If **Yes**, explain

_____

_____

Have you had oral surgery in the past __Yes __No

If yes, explain _____

Have you had orthodontics (braces) in the past __Yes __No

Orthodontist Name: _____

Have you had periodontal treatment in the past? __Yes __No

Explain: _____

Do you have dental examinations on a routine basis? __Yes __No

Last visit date: _____

Name of previous dentist _____

Date of last full mouth x-rays _____

Have your past experiences in a dental office always been positive? __Yes __No

Explain _____

Do you think you have active decay or gum disease? __Yes __No

Do you brush and floss on a routine basis? __Yes __No

Do you want to keep your remaining teeth? __Yes __No

Do you smoke or chew tobacco? __Yes __No

Type _____ Amount _____

Do you consume alcohol? __Yes __No Quantity _____

Do you prefer to use nitrous oxide (laughing gas) for dental procedures? __Yes __No

PLEASE CHECK IF THE FOLLOWING CONDITIONS APPLY TO YOU

__ Bad Breath
__ Bleeding, sore gums
__ Loose teeth
__ Food catches between teeth
__ Shifting teeth
__ Headache
__ Neck Ache
__ Clicking or popping jaw joints
__ Difficulty opening mouth
__ Facial pain
__ Ringing in ears
__ Difficulty chewing
__ Bell's Palsy
__ Trigeminal neuralgia

__ Teeth sensitive to biting
__ Teeth sensitive to sweets
__ Teeth sensitive to __Hot __Cold
__ Excessive wear of teeth
__ Discolored teeth
__ Snore
__ Ear congestion
__ Clenching or grinding of teeth
__ Difficulty swallowing
__ Sores in mouth
__ Swelling or lumps in mouth, head or neck
__ Pain / discomfort with dentures / partials
__ Poorly fitting dentures / partials
__ Nervousness / Insomnia

Is there anything that you would like to change about your smile? _____

Do you like the shape of your teeth? _____

Do you like the color of your teeth? _____

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Patient Name _____ Date _____

MEDICAL HISTORY

Are you under a physicians care at this time? __Yes __No Have you been in the past two years? __Yes __No
If yes explain_____
Name of physician _____ Phone Number _____
Have you been hospitalized or had a major operation? __Yes __No Explain _____
Have you ever had a serious injury to your head or neck? __Yes __No Explain _____
Are you taking any medications (including over the counter, vitamins and herbal products) __Yes __No

Medication	Dosage	Amount Taken Daily	Medication	Dosage	Amount Taken Daily

_____
_____
_____

Are you on a special diet? __Yes __No Explain _____
Are you allergic to any medications or substances listed below?
__Aspirin __Penicillin __Codeine __Latex __Acrylic __Metal __Other (list) _____

For Women Only
Are you pregnant? __Yes __No Due Date _____
Are you trying to get pregnant? __Yes __No Are you nursing? __Yes __No
Are you taking birth control pills? __Yes __No
Please notify us immediately if you become pregnant.

PLEASE INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD, OR HAVE AT PRESENT:

__AIDS	__Congenital Heart Disorder	__Heart Surgery	__Radiation Therapy
__Allergies/Hives	__Cortisone Medication	__Hemophilia	__Renal Dialysis
__Anemia	__Cosmetic Surgery	__Hepatitis A Infection	__Respiratory Problems
__Angina/chest pain	__Diabetes	__Hepatitis B (serum) or C	__Rheumatic Fever
__Arteriosclerosis	__Drug Addition	__High Blood Pressure	__Rheumatism
__Arthritis	__Emphysema	__HIV Positive	__Sickle Cell Disease
__Artificial Heart Valve	__Epilepsy or seizures	__Jaundice	__Sinus Trouble
__Artificial Joint	__Excessive Bleeding	__Kidney Trouble	__Sleep Apnea Disorder
__Asthma	__Fainting or Dizzy Spells	__Leukemia	__Stomach/Intestinal
__Blood Disease	__Frequent Cough	__Liver Disease	__Stroke
__Blood Transfusion	__Glaucoma	__Lung Disease	__Swelling of Limbs
__Breathing problem	__Hay Fever	__Mental Disorders	__Thyroid Problem
__Bruise Easily	__Heart Attack	__Mitral Valve Prolapse	__Tuberculosis
__Cancer/ Tumors	__Heart Disease	__Nervous Disorders	__Ulcers
__Chemotherapy	__Heart Failure	__Pacemaker	__Venereal Disease
__Cold Sores	__Heart Murmur	__Recent Weight Loss	__None of the Above

Do you have or have you had any disease, condition or problems not listed above? __Yes __No
Explain _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR MEDICATION, I WILL INFORM THE DENTIST OR DENTAL TEAM MEMBER IMMEDIATELY.

Sign _____ Date _____

DR. RANDALL PALMORE, DMD, FAGD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices

_____ *_____
Please print name Signature

_____
Date

*I give Dr. Palmore's office permission to release my records to "Specialists" or other dental offices as necessary for optimal dental care.

Please list individuals that you would allow your information to be released to, or discussed:

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

Other (please specify) _____

RANDALL PALMORE, D.M.D., F.A.G.D.

OFFICE FINANCIAL POLICY

The office policy is on a cash basis, at the time of service. The office will accept assignment of insurance with the understanding that when the deductible has not been met, the deductible will be due at the time a service is rendered. The insurance company will have notice of that charge being applied to your deductible. At the time dental treatment is rendered we will estimate the portion covered by your insurance carrier. The patient will be responsible for paying the difference. Any unpaid portion after insurance responds is the patient's responsibility.

We gladly accept Discover, Visa, American Express and Master Card, which allow you to make monthly payments to them for your dental treatment, as well as cash or check.

The office policy does allow for further financial assistance to be made in advance of treatment. The paperwork for additional financial assistance is handled by CARE CREDIT. A short acceptance of terms form will be completed in our office and faxed to CARE CREDIT. These options have been designed to assist you in handling the cost of dental treatment. IN ORDER TO KEEP YOUR COST AT AN ABSOLUTE MINIMUM WE ASK THAT YOU COOPERATE WITH THESE GUIDELINES OF FINANCIAL ARRANGEMENTS.

The high overhead cost of a dental practice will not allow us to carry open accounts. Billing patients is very expensive therefore we have designed our financial policy to avoid this additional cost.

In the even an account becomes delinquent this office will attempt to notify the responsible party. Severely delinquent accounts will be turned over to a collection agency and necessary collection fees will be applied.

I HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICY, AND I AGREE TO FOLLOW THESE GUIDELINES.

Signature _____ Date _____