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.

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Child Registration Form

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as possible. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health!

Name of patient _____ Birth date _____

Date _____ Who may we thank for referring you? _____

Nickname _____ Sex _____ Home Phone _____

Street Address _____

City _____ State _____ Zip Code _____

Name of School _____ Minor's SS# _____

NAME ON FAMILY ACCOUNT _____

Parent's Name _____ Relationship _____

Email Address _____ Home Phone _____

Address (if different) _____

Birthdate _____ SS# _____ Driver's License # _____

Employer _____ Work Phone _____

Parent's Name _____ Home Phone _____

Address (if different) _____

Birthdate _____ SS# _____ Driver's License # _____

Employer _____ Work Phone _____

List other family members that are patients _____

PLEASE PRESENT DENTAL INSURANCE CARDS
SO WE MIGHT DUPLICATE FOR OUR RECORDS

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

Signature of Responsible Party _____

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Health Information

Physician's Name _____ Phone Number _____

Former Dentist _____ Date of Last Exam _____

Please check if any of the following conditions apply to you:

_____ Bad Breath
_____ Food Collection Between Teeth
_____ Bleeding, sore gums
_____ Sensitivity to sweets
_____ Sensitivity to biting
_____ Sores or growths in mouth
_____ Shifting of teeth
_____ Periodontal treatment in the past
_____ Sensitivity to cold or hot
_____ Clicking or popping jaws
_____ Grinding teeth
_____ Loose teeth
_____ Swellings, lumps in mouth

How often do you brush _____ Floss _____

List ALL medications you are currently taking _____

List allergies _____

_____ Consume alcohol?

_____ Smoke cigarettes, cigars or pipe? _____ Quantity

_____ Chew smokeless tobacco? _____ Quantity

Please choose Y (yes) or N (no) in the following blanks as the condition applies to you.

_____ AIDS	_____ Dizziness	_____ Hepatitis	_____ Rheumatic Fever
_____ Anemia	_____ Emphysema	_____ High Blood Pressure	_____ Sinus Problems
_____ Arthritis	_____ Epilepsy	_____ HIV Disease	_____ Shortness of breath
_____ Asthma	_____ Fainting	_____ Joint Replacement	_____ Stroke
_____ Back Problems	_____ Glaucoma	_____ Kidney Disease	_____ Swelling
_____ Blood Disorder	_____ Head Aches	_____ Liver Disease	_____ Thyroid
_____ Cancer	_____ Heart Murmur	_____ Mitral Valve	_____ Tuberculosis
_____ Cough	_____ Heart Problems	_____ Psychiatric Care	_____ Tumor
_____ Diabetes	_____ Hemophilia	_____ Respiratory	_____ Ulcer

PLEASE NOTIFY US IMMEDIATELY IF YOU BECOME PREGNANT

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 immediately.

Signed _____ Date _____

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) _____

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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 allows 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 _____