# Dickerson Family Dental

Rein M. Dickerson DDS PLLC

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Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have questions regarding your treatment, your appointments or fees, please feel free to ask. This acquaintance form will help us to serve you better.

Date ______________________

Patient Name ____________________________________________
LAST FIRST MIDDLE

Street ______________________________ Apt. # ______________

City ______________________________ State __________ Zip Code __________

Home Ph. __________ Cell __________ Work __________ E Mail __________

Date of Birth ____/____/____ Sex: Male ____ Female ____ Marital Status: __________

Drivers License # ______________________ Social Security # ______________________

**Employer Information**

Employed by ______________________________ Since ______________

Street ______________ City ______________ State ______ Zip Code ______

Business Phone ______________ Extension # ______________

Nearest friend or relative we may notify *in case of emergency* ______________ *Ph. #* ______________

Whom may we thank for referring you? ______________________________

Name of your physician (family doctor) ______________________________ Ph. # ______________

Pharmacy Name ______________________________ Ph. # ______________

## Person Financially Responsible / Insurance Policy Holder

Name ____________________________________________
LAST FIRST MIDDLE

Street ______________ City ______________ State ______ Zip Code ______

Home Phone ______________ Cell Phone # ______________

Date of Birth ______________ Sex: Male ____ Female ____ Social Security # ______________

Employed by ______________________________ Phone ______________

Street ______________ City ______________ State ______ Zip Code ______

**Insurance Information**

Patients dental insurance carriers name ______________________________

Street ______________ City ______________ State ______ Zip Code ______

Group number ______________________________ Policy number ______________

# GENERAL HEALTH INFORMATION

DATE: ____________________

PATIENT NAME: ______________________ (LAST) ______________________ (FIRST) BIRTH DATE: __________ AGE: __________

## DENTAL HISTORY

1. **Reason for Visit / Main Concern**? Check-Up ☐ Cleaning ☐ Toothache ☐ Other ______________________
2. Are there other conditions of which we should be aware? YES ◯ NO ◯ If yes, please specify: ______________________
3. When did you last visit a dentist? ______________________
4. What treatment was performed? ______________________
5. Was the treatment completed? ______________________
6. When were dental x-rays taken? ______________________
7. Did you have a cleaning ? YES ◯ NO ◯
8. Have you had gum (periodontal) treatment? YES ◯ NO ◯
9. Have you ever had prolonged bleeding after an extraction? YES ◯ NO ◯ If yes, please specify: ______________________
10. Have you had any problems with past dental treatment? YES ◯ NO ◯ If yes, please specify: ______________________
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES ◯ NO ◯ If yes, please specify: ______________________
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES ◯ NO ◯ If yes, please specify: ______________________
13. Do your gums bleed easily? YES ◯ NO ◯
14. Do you feel you have bad breath? YES ◯ NO ◯
15. Are your teeth sensitive to hot or cold? YES ◯ NO ◯
16. Would you like your teeth whiter? YES ◯ NO ◯
17. Are you happy with your smile? YES ◯ NO ◯ If no, please explain: ______________________

## MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ◯ NO ◯ If yes, please specify: __________ Dr. Name: ______________________
   Dr. Phone: ( ) ______________________
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? ______________________
3. Are you taking any medications at this time, including birth control? YES ◯ NO ◯ If yes, please specify: ______________________
4. (Women) Are you pregnant now? YES ◯ NO ◯ If yes, how many months? __________ Are you nursing? YES ◯ NO ◯
5. Are there any other health problems of which we should be advised? Please specify: ______________________
6. Do you have, or have you had, any of the following?

**Please check "YES" or "NO"**

| Condition | YES | NO |
|---|---|---|
| ARTIFICIAL HEART VALVE | YES ◯ | NO ◯ |
| AIDS/HIV+ | YES ◯ | NO ◯ |
| ANEMIA | YES ◯ | NO ◯ |
| ANGINA | YES ◯ | NO ◯ |
| ARTHRITIS | YES ◯ | NO ◯ |
| ASTHMA | YES ◯ | NO ◯ |
| BISPHOSPHONATE THERAPY | YES ◯ | NO ◯ |
| BLEEDING PROBLEMS | YES ◯ | NO ◯ |
| CANCER | YES ◯ | NO ◯ |
| CHEMO/RAD THERAPY | YES ◯ | NO ◯ |
| COSMETIC SURGERY | YES ◯ | NO ◯ |
| DIABETES | YES ◯ | NO ◯ |
| DIZZY SPELLS | YES ◯ | NO ◯ |
| DRUG ADDICTION | YES ◯ | NO ◯ |
| EMPHYSEMA | YES ◯ | NO ◯ |
| EPILEPSY | YES ◯ | NO ◯ |
| FAINTING | YES ◯ | NO ◯ |
| GLAUCOMA | YES ◯ | NO ◯ |
| HEART ATTACK/SURGERY | YES ◯ | NO ◯ |
| HEART MURMUR/PROBLEMS | YES ◯ | NO ◯ |

**Please check "YES" or "NO"**

| Condition | YES | NO |
|---|---|---|
| HEPATITIS | YES ◯ | NO ◯ |
| HIGH BL. PRESSURE | YES ◯ | NO ◯ |
| JAUNDICE | YES ◯ | NO ◯ |
| JOINT REPLACEMENT | YES ◯ | NO ◯ |
| KIDNEY DISEASE | YES ◯ | NO ◯ |
| LATEX ALLERGY | YES ◯ | NO ◯ |
| LIVER PROBLEMS | YES ◯ | NO ◯ |
| LOW BL. PRESSURE | YES ◯ | NO ◯ |
| LUNG DISEASE | YES ◯ | NO ◯ |
| PACEMAKER | YES ◯ | NO ◯ |
| PSYCHIATRIC CARE | YES ◯ | NO ◯ |
| RHEUMATIC FEVER | YES ◯ | NO ◯ |
| SINUS TROUBLE | YES ◯ | NO ◯ |
| SLEEP APNEA | YES ◯ | NO ◯ |
| TOBACCO | YES ◯ | NO ◯ |
| STROKE | YES ◯ | NO ◯ |
| THYROID PROBLEMS | YES ◯ | NO ◯ |
| TMD OR TMJ | YES ◯ | NO ◯ |
| TUBERCULOSIS | YES ◯ | NO ◯ |
| VENEREAL DISEASE | YES ◯ | NO ◯ |

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.*

Patient's signature ______________________ (Parent if Patient is a Minor) Date ______________________

Doctor Signature ______________________

Pharmacy Name: ______________________

HIPAA OMNIBUS RULE

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ______________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

______________________ ______________________

Please ***print*** your name Please ***sign*** your name

______________________ ______________________

Legal Representative Description of Authority

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA: ☐ First Name Only ☐ Proper Sir Name ☐ Other ______________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ______________ Relationship: ______________

Name: ______________ Relationship: ______________

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation ☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

______________________
Signature of Privacy Officer

***HIPAA made EASY™***

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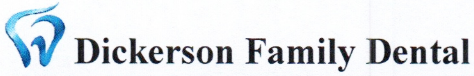


Office Financial Policy

Welcome to Dickerson Family Dental. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information.

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard, American Express and Care Credit.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental insurance wallet card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening arises. If an appointment is not canceled at least 24 hours in advance, or if you fail to keep your appointment, you will be charged a seventy-five-dollar ($75) fee. This fee will not be covered by your insurance company.

Separated or divorced parents of minors, who are responsible for one half of the cost of a child's/children's dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee

I have read and understand this financial policy.

________________ ________________ ________

Printed Name | Signature | Date