Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Primary Phone _____

Address _____ City _____ State/ Prov. _____ Zip/Post P.C. _____

Email _____ Secondary Phone _____

Check Appropriate Box. ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State/ Prov. _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State/ Prov. _____ Zip/Post P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

X _____

Signature of patient (or parent if minor)

Over Please

Medical History

Name _____ DOB _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain: _____

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____

Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? O Yes O No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No _____

Are you on a special diet? O Yes O No

Do you use tobacco? O Yes O No

Do you use controlled substances? O Yes O No

Women: Are you

☐ Pregnant? ☐ Trying to get pregnant?

☐ Taking oral contraceptives? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Rheumatism
☐ Alzheimer's Disease	☐ Congenital Heart Disorder	☐ Genital Herpes	☐ Kidney Problems	☐ Scarlet Fever
☐ Anaphylaxis	☐ Convulsions	☐ Glaucoma	☐ Leukemia	☐ Shingles
☐ Anemia	☐ Cortisone Medicine	☐ Hay Fever	☐ Liver Disease	☐ Sickle Cell Disease
☐ Angina	☐ Defibrillator/Pacemaker	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Artificial Joint	☐ Easily Winded	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Asthma	☐ Emphysema	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Breathing Problem	☐ Excessive Thirst	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Fainting Spells/Dizziness	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Cough	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
☐ Chest Pains	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatic Fever	☐ Venereal Disease
				☐ Yellow Jaundice

Have you had, any serious illness not listed above? O Yes O No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Family Dental Care of Dothan
Dr. Keith A. Blackmon, D.D.S.

Financial Policy

Payment is due at the time of service. For your convenience, we accept Cash, Checks, Visa, MasterCard, American Express, Discover, Debit/Bank cards and Care Credit. There will be a $30 charge for a returned check. We do not offer payment plans. However, we will be glad to assist you with a CareCredit application.

Regarding Insurance
We are happy to file your insurance as a courtesy. If for any reason your insurance does not cover any procedure that is performed, payment is YOUR responsibility. We will attempt to verify your coverage and your copay as accurately as possible. However, you are ultimately responsible for your account. Please understand that your insurance policy is a contract between you, your employer and your insurance company. The estimate provided is to be considered a guideline until the final insurance payment is received. We will gladly assist in determining your coverage, but the final responsibility is yours.

Past-Due Account Balances
Interest of 1.5% may be charged to accounts over 60 days. All accounts over 120 days may be reported to the Credit Bureau. Patients will be responsible for all collection and/or attorney fees which could incur why trying to collect on a bad debt by Family Dental Care of Dothan.
Proper legal proceedings surrounding the outstanding balance and debt shall be initiated and litigated in the court of the appropriate jurisdiction of Houston County, Alabama. I hereby wave any and all defenses and/or objections to said jurisdiction. I also agree that if I reside in Florida, I will waive any head of household exemption to avoid garnishment of my wages should be same required. I grant permission to you or assignees, to telephone me at home, work or the cell phone listed, to discuss matters concerning my account or treatment.

Appointments
Please note that we may find it necessary to charge a No Show Fee of $40-$75 if you do not give at least a 24 hour notice when canceling your appointment or if you do not show up for an appointment. Cancellation in advance allows your appointment time to be offered to other patients who may have urgent healthcare needs.

By signing below, I acknowledge that I have read and understand the above financial polices. I authorize the release of any medical or other information necessary to process my claims. I authorize payment of benefits to Family Dental Care of Dothan.

I have read and agree to the above financial policy.

_____ _____

Patient/Responsible Party Signature Date

Family Dental Care of Dothan
Dr. Keith A. Blackmon, D.D.S.

Notice of Privacy Practices

Your medical information is personal and we are committed to protect this information. We create a record of the care and services at our office and these records are used to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office.

The following describes the different ways that your information may be used or disclosed by this office.

For Treatment: We may use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to your referring dentist, doctors, nurses, technicians and other office personnel who are involved in providing you treatment.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. We may contact you via home, work or cell phone and leave messages or text message, email and/or postcards/letters in order to notify you of any appointments or changed appointments.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

Electronic Communication: We may communicate your health information to healthcare providers and insurance companies via email or other electronic methods.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law.

I have read and understand the above and agree to the conditions listed above, thereby giving consent for x-rays and treatment, mutually agreed upon, to be rendered for me/my child

Signed: _____ **Date:** _____

Print patient name _____

Release of Medical Information: I give consent for persons listed below to receive information concerning medical/dental records, to include insurance information, financial information, making and canceling appointments on behalf of me or my child.

Patient/Guardian signature: _____ **Date:** _____

Name_____ Relationship to patient_____Phone #_____

Name_____Relationship to patient _____ Phone#_____

If no one is listed above NO information will be given to anyone other than the patient/parent/guardian.