

Welcome to our Practice

Patient Information:

Today's Date: _____

First Name _____ MI _____ Last Name _____

Birth Date _____ Age _____ SSN _____ Sex: Male Female

Cell: _____ Home: _____ Email: _____

Street: _____ City: _____ State: _____ Zip: _____

Dentist: _____ Orthodontist: _____ Dr.: _____

Married Divorced Single Widow Legally Separated Pharmacy: _____

In case of emergency, please contact: _____ Tel: _____

Who will be responsible for your account:

Self (If self, skip this section) Spouse Father Mother Other _____

Name: _____ Birth Date: _____ SSN _____

Cell: _____ Home: _____ Email: _____

Street: _____ City: _____ State: _____ Zip: _____

Driver's Lic #: _____ Employer: _____ Bus Tel: _____

Primary Dental Insurance Company:

Primary Medical Insurance Company:

Ins. Co. Name: _____

Ins. Co. Name: _____

ID#: _____ Grp #: _____

ID#: _____ Grp #: _____

Insurance Address: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Tel: _____

Tel: _____

Insured Party: _____

Insured Party: _____

Relation: _____ Date of Birth: _____

Relation: _____ Date of Birth: _____

Secondary Dental Insurance Company:

Secondary Medical Insurance Company:

Ins. Co. Name: _____

Ins. Co. Name: _____

ID#: _____ Grp #: _____

ID#: _____ Grp #: _____

Insurance Address: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Tel: _____

Tel: _____

Insured Party: _____

Insured Party: _____

Relation: _____ Date of Birth: _____

Relation: _____ Date of Birth: _____

Health History:

- Reason for today's office visit? _____ **Yes No**
1. **Height** _____ **Weight** _____ Are you in good health?.....
2. Have you had any illness, operation or been hospitalized in the past five years?.....
If so, describe _____
3. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?
If so, describe _____
4. Do you have a prosthetic joint/ implant?..... **If so, describe where** _____
5. Have you had a heart valve or vascular graft?.....

COVID-19:

6. Have you recently been tested for COVID-19 and awaiting results? If yes, when? _____
7. Have you recently been diagnosed with COVID-19? If yes, when? _____
8. Are you fully vaccinated or in the course of being vaccinated for COVID-19? **Yes** **No**
9. Have you been in contact with any confirmed cases of COVID-19 in the last 14 days? **Yes** **No**

Women Only: (Questions 10-13)

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 10. Is there a possibility of pregnancy?..... | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Expected delivery date: _____ | | | 13. Are you taking birth control pills?... | <input type="checkbox"/> | <input type="checkbox"/> |

Have you had or do you currently have:

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 14. Damaged heart valves/ Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | 32. Convulsions/ epilepsy/seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | 33. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 34. Thyroid trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Chest pain/ angina | <input type="checkbox"/> | <input type="checkbox"/> | 35. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Heart Attack(s) | <input type="checkbox"/> | <input type="checkbox"/> | 36. Swollen legs or ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Irregular heart beat | <input type="checkbox"/> | <input type="checkbox"/> | 37. Osteoporosis/ osteopenia | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Cardiac pacemaker/ stent | <input type="checkbox"/> | <input type="checkbox"/> | 38. Stomach ulcers/ acid reflux | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | 39. Infectious diseases (ex: HIV/ Hep-C) | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Pneumonia, bronchitis, chronic cough | <input type="checkbox"/> | <input type="checkbox"/> | 40. Problems with immune system possibly from medication/ surgery etc. | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Asthma | <input type="checkbox"/> | <input type="checkbox"/> | 41. Delay in healing | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Sleep apnea/ CPAP/ snoring | <input type="checkbox"/> | <input type="checkbox"/> | 42. A tumor or growth | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Difficulty breathing/ lung trouble | <input type="checkbox"/> | <input type="checkbox"/> | If yes, when and where _____ | | |
| 26. Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | 43. Radiation to the head or neck | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you smoke or use chewing tobacco | <input type="checkbox"/> | <input type="checkbox"/> | 44. Cancer/radiation/chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, number of packs a day _____ | | | If yes, when and where _____ | | |
| 28. Eye disease/ glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | 45. Mental health problems/ anxiety/ Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Kidney disease/ dialysis | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 30. Bleeding tendency/ abnormal bleed | <input type="checkbox"/> | <input type="checkbox"/> | 46. Pain or clicking of the jaws | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Hepatitis, jaundice, or liver disease | <input type="checkbox"/> | <input type="checkbox"/> | 47. History of drug/ alcohol abuse | <input type="checkbox"/> | <input type="checkbox"/> |

Have you had or do you currently have: **Are you allergic, or had a reaction to:**

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 48. Blood thinners (Coumadin, Plavix, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | 54. Local anesthetic (numbing meds.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. Diet Pills | <input type="checkbox"/> | <input type="checkbox"/> | 55. Antibiotics (Penicillin, Sulfa, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Are you taking or have you taken bone density medications, RANKL inhibitors or bisphosphonates (Fosamax, Boniva, Actonel, etc.) in the past 12 years | <input type="checkbox"/> | <input type="checkbox"/> | 56. Codeine or other narcotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. Marijuana or "street drug" | <input type="checkbox"/> | <input type="checkbox"/> | 57. Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. Please list all medications you are currently taking: | | | 58. Eggs or other food allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 59. Nickel or other metals | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 60. List all known allergies: | | |

Medication	Dosage

61. Is there any condition concerning your health the the doctor should be told about? **Yes** **No**
 If yes, describe _____
62. Is this visit related to an accident? **Yes** **No**
 If yes, what type of accident? _____
 Date of injury _____
63. Do you wish to speak with the doctor privately? **Yes** **No**

53. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking:
 Methadone Oxycodone Fentanyl Other
 Treating Doctor: _____
 (First Name) (Last Name)

Patient Acknowledgment- By signing this document I acknowledge that the Health History and Health Screening answers I have provided are true and accurate, also I understand and accept that there is a risk of COVID-19 exposure with treatment.

 Patient Signature Date Doctor Signature Date



PONTCHARTRAIN ORAL SURGERY

DR. C. BRADLEY DICKERSON

Financial Policy

OFFICE VISITS & SURGICAL CARE: Based on insurance benefits, payment is expected at the time of service. This includes charges for x-rays and other diagnostic studies. Alternate arrangement must be made in advance. If you do not have insurance coverage payment is due in full at the time of services rendered.

PAYMENT OPTIONS: For your convenience, we accept cash, check, and major credit cards. Financing is available through Care Credit.

INSURANCE: Your insurance coverage is a contract between you and your insurer; we are not a party to that contract. While we will gladly assist you in recovering maximum benefits from your plan, you are ultimately responsible for your account with our office, in lieu of any third party charges.

Please note, we file your insurance as a courtesy. It is the patient's responsibility to know benefits and to contact the carrier with any questions regarding your network or coverage. Please remember to bring your insurance card and picture ID to every appointment.

If after a 3 month period your PPO has not paid, the patient will be automatically responsible for payment of the entire balance unless an alternate payment has been made with our office.

Accounts with a balance over 120 days will be turned over to a collection agency. Collection agency fees will be responsible for the account holder.

MEDICARE: Our office is not a Medicare provider. Therefore, we do not file Medicare or secondary Medicare claims.

PATHOLOGY/LAB WORK: For any procedure done in our office requiring an analysis and pathology report, you will be billed separately by the rendering lab.

Signature

Date

Relationship to patient

Witness



**PONTCHARTRAIN
ORAL SURGERY**
DR. C. BRADLEY DICKERSON

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

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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