Pickett Family Dental

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address *(If different)* _____ Date of Birth _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial: _____

Telephone (☐Mobile ☐Work ☐Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature _____ Date _____
(Responsible Party, if under 18)

PATIENT REGISTRATION

Pickett Family Dental

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ PATIENT FIRST NAME: _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	☐	☐	Head, neck, jaw pain, or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Chew on one side of mouth	☐	☐	Mouth breathing	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Orthodontic treatment	☐	☐
Smokeless tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐
Food collection between teeth	☐	☐	Sensitivity to pressure or irritants	☐	☐
Clench or grind teeth	☐	☐	(cold, heat, sweets)		
Growths or sore spots in your mouth	☐	☐	How often do you floss? _____		
Gums swollen, tender or bleeding	☐	☐	How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐Yes ☐No

If Yes, please explain _____

_____

_____

Have you ever had trouble from previous dental care?

☐Yes ☐No If Yes, please explain _____

_____

_____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____

Have you had any serious illnesses or operations Yes ☐ No ☐ If yes, please describe _____

Have you ever had a blood transfusion Yes ☐ No ☐ If yes, give approximate dates _____

(Women) Are you pregnant? Yes☐ No ☐ Due date _____ Nursing? Yes ☐ No☐ Taking birth control pills? Yes ☐ No ☐

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	☐	☐	Headaches	☐	☐	Slow healing wounds	☐	☐
Anemia	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Arthritis, Rheumatism	☐	☐	Heart problems	☐	☐	Swelling of feet or ankles	☐	☐
Artificial heart valves	☐	☐	Hepatitis type _____	☐	☐	Thyroid problems	☐	☐
Artificial joints	☐	☐	Herpes	☐	☐	Tonsilitis	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐	Tuberculosis	☐	☐
Required Hospitalization	☐	☐	Any immune deficiency	☐	☐	Tumor or growth on head/neck	☐	☐
Have you used steroids	☐	☐	Jaundice	☐	☐	Ulcer	☐	☐
Date of last episode _____	☐	☐	Kidney disease	☐	☐	Venereal disease	☐	☐
Bleeding abnormally with operations or surgery	☐	☐	Low blood pressure	☐	☐	Weight loss, unexplained	☐	☐
Blood disease, clotting disorders	☐	☐	Mitral valve prolapse	☐	☐	Do you wear contact lenses?	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐	Do you consume alcoholic beverages?	☐	☐
Chemical dependency	☐	☐	Osteopenia	☐	☐	Are you currently under the care of a Physician?	☐	☐
Chemotherapy	☐	☐	Pacemaker	☐	☐	Are you allergic/sensitive to Latex?	☐	☐
Circulatory problems	☐	☐	Radiation treatments	☐	☐	Allergic to Penicillin, Aspirin, or other drugs?	☐	☐
Cortisone treatments	☐	☐	Respiratory disease	☐	☐	*If Yes, please specify* _____		
Cough, persistent or bloody	☐	☐	Rheumatic fever	☐	☐	_____		
Diabetes	☐	☐	Scarlet fever	☐	☐	_____		
Emphysema	☐	☐	Shortness of breath	☐	☐	List any medications that you are taking:		
Epilepsy	☐	☐	Sinus trouble	☐	☐	_____		
Fainting	☐	☐	Sickle cell anemia	☐	☐	_____		
Glaucoma	☐	☐	Skin rash	☐	☐	_____		

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____

DENTAL & MEDICAL HEALTH HISTORY

Pickett Family Dental

CONSENT TO PROCEED

I authorize Dr. Tyson Pickett and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature:_____ **Date:**_____

(Patient, legal guardian or authorized agent of patient)

Witness:_____ **Date:**_____

Office Policies & Patient Responsibilities

Thank you for choosing Pickett Family Dental for your oral health needs. It is our goal to provide you with a positive experience. Over the past few years, the practice of dentistry has become more complicated for doctors and patients alike.

Because of the growing complexity of the insurance business, we feel that we can no longer assume that patients fully understand the relationship between the insurance company, the doctor, and themselves. In an effort to clarify this relationship, we have established a set of guidelines regarding financial responsibility and office policies.

We will file your insurance for you:

- As a service to our patients with insurance, we will bill your carrier on your behalf to maximize your benefits. Patient portions are estimated based on information supplied by your insurance carrier to us and are not guaranteed to be exact, therefore, any amount not covered by your insurance is your responsibility.
- It is your responsibility to understand your insurance plan coverage. If you do not understand your policy, you may wish to contact them to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurances arbitrarily select certain services or treatment codes which they will not cover. Our office never guarantees that your insurance will pay for all services. We will make every attempt to file your claim as straightforward and simple as possible. However, if for any reason your claim is denied, you are responsible for the amount due on your account.
- If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card.
- There is a $20 charge for returned checks.
- We offer a courtesy accounting adjustment to patients who pay one week prior to treatment for treatment plans of $300 or more. If advanced payments are made by credit card, we offer a 2% savings, if by cash or check; we offer a 5% savings.
- NO INTEREST[1] Payment Plans[2] from Care Credit
  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties
- Pickett Family Dental requires payment at time of service
- For Oral Sedation and Oral Surgery, payment in full are required to secure your initial treatment appointment. There is a fee of $360.00 for Oral Sedation which is non-refundable, and not covered by any insurance company.

Collection Efforts:

- We will send you three statements regarding your balance. The second statement is considered past due. If you should receive a third statement noted “Final”, the account will be turned over to a collection agency. If you are sent to a collections agency, a 35% collections fee will be added to your balance.

Missed appointments, Late Cancellations, & Non-Compliance

- Please keep in mind that appointments are time-slots reserved specifically for you. We require 48-hour advance notice if you are unable to keep your scheduled appointment. As a courtesy, we offer appointment reminder emails, text messages and calls which will allow you to cancel or reschedule at that time. However, it is ultimately your responsibility to keep track of your appointment whether you receive a reminder or not.
- If you miss an appointment without 48-hours advance notice or cancel/reschedule within the same time period, a fee of $75 per hour scheduled may be incurred on your account. This fee is not billable to your insurance.
- If you are more than 20 minutes late, your appointment may be cancelled, and you will need to reschedule. We encourage new patients to show up 15 minutes early to complete their registration.
- Patients with repeat cancellations or missed appointments may be discharged from our practice
- Abusive/inappropriate behavior towards staff or other patients may result in dismissal of your care from our practice.

I have read and understand the above and agree to comply with the financial policies of Pickett Family Dental. My signature authorizes this office to file my claims and assigns to this office all rights to my dental reimbursement benefits under my insurance policy. I understand that my signature also allows this office to release information regarding my visits to my insurance carrier. I understand that I am responsible for my bills in the event the insurance company denies any claims or takes longer than 90 days to pay.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.[2]Subject to credit approval

APPENDIX I – Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	**Date of Birth:**

This consent form allows Pickett Family Dental to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Pickett Family Dental has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Pickett Family Dental.

____ Initial I hereby authorize Pickett Family Dental to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Information related to billing and payment.

___ Initial I hereby authorize that Pickett Family Dental may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

__ Email __ Home Phone __ Office Phone __ Cell Phone

___ Initial I hereby authorize that Pickett Family Dental may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

___ Initial I hereby authorize that Pickett Family Dental may disclose my personal health information to the person who I have listed as my emergency contact.

___ Initial I hereby authorize that Pickett Family Dental may disclose my personal health information to the following person(s):

Name	**Telephone Number**	**Relationship to Patient**

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Pickett Family Dental services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Pickett Family Dental may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Pickett Family Dental is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date:

Signature of Parent (if minor) / Authorized Representative _____ Date: