Welcome

WE ARE GLAD YOU CHOSE US FOR YOUR FAMILY DENTAL CARE. IT IS OUR MAIN GOAL TO MEET ALL OF YOUR GENERAL AND PREVENTATIVE DENTAL HEALTH CARE NEEDS. IN ORDER FOR US TO DO THIS, PLEASE FILL OUT THIS FORM COMPLETELY AND RETURN IT TO THE RECEPTIONIST. THE BETTER WE COMMUNICATE, THE BETTER WE CAN CARE FOR YOU. ALL INFORMATION IS, OF COURSE, CONFIDENTAL. IF YOU NEED ANY ASSISTANCE, PLEASE ASK US - WE WILL BE HAPPY TO HELP.

Date:_____

PATIENT INFORMATION

Cell #_____ **Soc Sec.#** _____

Name_____ **Birthdate**___/___/___ **Home Phone**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Patient's or Parent's Employer_____ **Work Phone**_____

Business Address_____ **City**_____ **State**_____ **Zip**_____

Spouse or Parent's Name_____ **Employer**_____ **Work Phone**_____

If Patient is a Student, Name of School/College?_____ **City/State**_____

Where and When Are The Best Times to Reach You?_____

Whom May We Thank For Referring You? _____

Person to Contact in Case of Emergency? _____ **Work#**_____ **Home#**_____

MEDICAL HISTORY

Age_____ **Sex**_____ **Wt.**_____ **Ht.**_____

Physician's name: _____ _____

Address: _____ _____

_____ _____

Phone#: _____ _____

yes	no	
❑	❑	Have you ever been told you need Antibiotic Prophylaxis (pre-medication) prior to any dental treatment?
❑	❑	Do you consider yourself to be in good health?
❑	❑	Are you currently under a physician's care?
❑	❑	Do you or have you taken Fosamax?
❑	❑	Are you currently taking any medications? If yes, please list:

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____

Are you aware of having an allergic or adverse reaction to any of the following:

❑ Penicillin ❑ Tetracycline ❑ Sulfa ❑ Erythromycin ❑ Latex
❑ Aspirin ❑ Dental Anesthetics ❑ Codeine ❑ Metals ❑ Other

Please list any other drugs or substances you are allergic to:_____

FEMALES: Are you: ❑ Pregnant? ❑ Nursing? ❑ Taking birth control pills?

Indicate which of the following you have had, or have at present.

- ❑ Heart (Surgery, Disease, Attack)
- ❑ Chest Pain
- ❑ Congenital Heart Disease
- ❑ Heart Murmur
- ❑ Low Blood Pressure
- ❑ High Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Artificial Heart Valve
- ❑ Heart Pacemaker
- ❑ Rheumatic Fever
- ❑ Arthritis/Rheumatism
- ❑ Cortisone Medication
- ❑ Swollen Ankles
- ❑ Stroke
- ❑ Diet (Special/Restricted)
- ❑ Artificial Joins (hip, knee, etc.)
- ❑ Kidney Disease
- ❑ Ulcers
- ❑ Diabetes
- ❑ Thyroid Problems
- ❑ Glaucoma
- ❑ Congestive Heart Failure
- ❑ C.O.P.D
- ❑ Emphysema
- ❑ Chronic Cough
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Latex Sensitivity
- ❑ Allergies or Hives
- ❑ Sinus Trouble
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Tumors/Cancer
- ❑ Leukemia
- ❑ Back/Neck Problems
- ❑ Hepatitis
- ❑ Venereal Disease
- ❑ A.I.D.S./H.I.V. Positive
- ❑ Cold Sores/Fever Blisters
- ❑ Blood Transfusion
- ❑ Hemophilia
- ❑ Sickle Cell Disease/Trait
- ❑ Bruise Easily
- ❑ Liver Disease
- ❑ Yellow Jaundice
- ❑ Neurological Disorders
- ❑ Epilepsy or Seizures
- ❑ Fainting or Dizzy Spells
- ❑ Nervous/Anxious
- ❑ Psychiatric/Psychological Care
- ❑ Drug/Alcohol Abuse

Do you have or have you had any disease, condition, or problem not listed? ❑ no ❑ yes

If yes, please list:_____

DENTAL HISTORY

Date of last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

Previous Dentist's Name _____ City _____

How often do you brush? _____ Floss? _____

Have you ever had a problem with dental treatment?	**yes**	**no**
bleeding.....	☐	☐
swelling.....	☐	☐
drug reaction.....	☐	☐
dry socket.....	☐	☐

Have you ever been instructed regarding	**yes**	**no**
proper home care of your teeth or gums?	☐	☐
Do you:		
frequently get cold sores, blisters, or other oral lesions?.....	☐	☐
smoke/chew tobacco?.....	☐	☐

Have you ever had:

☐ full or partial dentures?

If so, how long?_____

How long have you worn your current prosthesis?_____

Have you ever had a reline?_____

Are you presently having any problems with your dentures? Describe:_____

Describe:_____

☐ serious injury to the: ☐ mouth ☐ jaw ☐ face ☐ head

Do you feel nervous about having dental treatment? ☐ no ☐ yes

What is our biggest concern?_____

RESPONSIBLE PARTY

Name of Person Responsible for Account _____

Relation ship to Patient _____

Address _____ Home Phone_____

Soc Sec. #_____ Drivers's License#_____ Birth Date _____

Employer_____ Work Phone _____

Method of Payment: ☐CASH ☐CHECK ☐CREDIT CARD ☐MEDICAID ☐INSURANCE

INSURANCE INFORMATION

Name of insured_____ Relationship to Patient_____

Soc Sec. #_____ Birthdate_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State___Zip_____

Insurance Company_____ Group #_____ Identification #_____

Ins. Co. Address_____ City_____ State___ Zip_____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit?_____

Preventive_____% Basic_____% Major_____% Radiographs_____ Sealants_____

If you have additional insurance, please ask for additional forms.

AUTHORIZATION AND RELEASE

I certify that the above information is complete and accurate to the best of my knowledge. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. I will notify the dentist of any change in my health or medication. I hereby authorize doctor or designated staff to take radiographs, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of myself or child's dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Due to the increased cost of mailing statements and trying to keep fees as low as possible, we find it necessary to expect our patients to pay for the services they receive at that time, unless prior arrangements have been made. I authorize and request my insurance company to pay directly to the dentist insurance benefits other wise 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. In the event that payment for dental services is not made within sixty (60) days of treatment, then interest at the legal prevailing rate, plus a service charge may be added to the past due balance. If collection and/or legal services are required to receive payment of the past due balance, I will be responsible for all collection costs and reasonable attorney fees incurred in connection with the collection efforts. A minimal charge may be assessed for failed or cancelled appointments without at least 24 hour prior notification.

Signature of Patient/Guardian_____Date_____

Signature of Dentist_____Date_____

Collier Dental
2162 South Lamar Boulevard
Oxford MS 38655

Acceptance of Disclosure Statement

I have read a copy of the Notice of Privacy Practices for Protected Health Information and have had an opportunity to ask questions concerning that Notice given to me by Dr. John Collier or his staff.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Date

_____ Accepted _____ Declined

I request the following restrictions to the use or disclosure of my health and/or dental information.

_____

You are responsible for knowing the benefits of your insurance policy. Any estimates given are subject to be denied by your insurance company. By signing below, I am aware that I am responsible for payment of any denied services.

_____ _____

Insured Date

In Order to Serve You Better, we have a few questions:

1. What is your email?

2. Would you like to be e-mailed or text messaged to confirm future appointments?

3. How did you hear about us?

4. What did you like about your former dentist?

Financial Policy

Patients with Dental Insurance: As a courtesy to you, our office will gladly submit services to your insurance. We are able to bill to traditional, indemnity insurance plans. We do not accept DMO or DPO plans (Dental Maintenance or Dental Provider Organizations). Under these plans, there is **NO COVERAGE** when treatment is rendered by a non-participating dentist. Please review you plan type carefully. We an in-network a provider with many policies: Delta Dental Premiere, Connection Dental, Guardian, Humana, United Concordia, MS Medicaid, MS Can, and MS Chips. For specific information about in or out-of-network benefit amounts please contact your insurance company.

Authorization to Release Info and Assignment of Benefits: I certify that I, _____, (or my dependent) have (has) dental insurance coverage and assign directly to Collier Dental all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or the staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

Payments: We accept cash, check, all major credit cards, Wells Fargo, Citi, and Care Credit. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot **guarantee** the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Should an outstanding balance result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you.

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past Due Accounts: If payment is not received by the due date printed on the statement, then your account is considered "past-due". We reserve the right to impose a service charge of 2% per month (18% per annum) on the unpaid balance on all accounts exceeding 30 days, unless previous financial arrangements have been made. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Patients without Dental Insurance: Payment in full is expected at the time services are rendered. We accept cash, check, all major credit cards, Wells Fargo, Citi, and Care Credit.

Broken/Missed Appointments: We request at least 48 hours' notice before canceling or rescheduling an appointment. That way, we have time to fill the opening in our schedule. We reserve the right to charge your account $25.00 if we are notified at least 24 hours before your appointment. Thank you for assisting us in keeping our schedule full.

Collier Dental reserves the right to update and make changes to the above-stated financial policies at any time without prior notification.

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Patient Name (print):_____ Date:_____

Responsible Party Signature: _____

Relationship to Patient: _____

August 28, 2013