

Huckabee Dental
Family, Cosmetic & Implant Dentistry

Patient Information

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

NAME: _____ DATE: _____
 Last First Middle

I LIKE TO BE CALLED: _____ EMAIL ADDRESS: _____
 Male Female Single Married Divorced Widowed

ADDRESS: _____
 Street Apt# City State Zip

BIRTH DATE: _____ TELEPHONE: _____
 M/D/YY Home Cell

DRIVERS LICENSE# _____ SOCIAL SECURITY# _____

PLACE OF EMPLOYMENT: _____ WORK # _____

DENTAL INSURANCE CARRIER: _____ GROUP # _____

Has any member of your family ever been treated in our office? Yes No

Whom may we thank for referring you to our office? (check all that apply)

- Newspaper I saw your sign Yellow Pages Advertisement
 My Friend: _____ My physician: Dr. _____

FAMILY INFORMATION							
My Husband's / Father's Information				My Wife's / Mother's Information			
Last	First	MI		Last	First	M.	
Street	City	St.	Zip	Street	City	St.	Zip
Home Telephone #		Cell Telephone #		Home Telephone #		Cell Phone #	
Birth Date (M/D/YY)		SS#		Birth Date (M/D/YY)		SS #	
Employer		Work Telephone #		Employer		Work Telephone #	
Dental Insurance		Group #		Dental Insurance		Group #	

PERSON TO CONTACT IN CASE OF EMERGENCY
 Outside of immediate family / household

Name: _____
 Address: _____ Telephone Number: _____

Person responsible for this account: Myself My Spouse My Parent Other _____

Please Continue to next page...

Initial blood pressure: _____

Medical History

Who was your previous dentist? _____

When was the last time you had dental x-rays taken? _____

Have you ever had a major operation? Yes No Describe: _____

Have you ever had a head or neck injury? Yes No Describe: _____

Are you taking any medication now? Yes No Describe: _____

Are you allergic to any of the following:

Aspirin	<input type="checkbox"/> No <input type="checkbox"/> Yes	Acrylic	<input type="checkbox"/> No <input type="checkbox"/> Yes	Penicillin	<input type="checkbox"/> No <input type="checkbox"/> Yes
Latex Rubber	<input type="checkbox"/> No <input type="checkbox"/> Yes	Codeine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes

Do you have any of the following:

Artificial Limb	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular Heart Beat	<input type="checkbox"/> No <input type="checkbox"/> Yes	Convulsions	<input type="checkbox"/> No <input type="checkbox"/> Yes	Renal Dialysis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mitral Valve Prolapse	<input type="checkbox"/> No <input type="checkbox"/> Yes	Scarlet Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Blood Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Venereal Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Low Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis A B C	<input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Excessive Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hemophilia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rx Diet Pills	<input type="checkbox"/> No <input type="checkbox"/> Yes	Leukemia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Recent Transfusion	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cold Sores	<input type="checkbox"/> No <input type="checkbox"/> Yes	Swelling of limbs	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tuberculosis (TB)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Drug Addiction	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Breathing Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	HIV Positive	<input type="checkbox"/> No <input type="checkbox"/> Yes	Radiation Therapy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chemotherapy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Genital Herpes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Ulcers	<input type="checkbox"/> No <input type="checkbox"/> Yes
Digestive Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hypoglycemia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Recent Weight Loss	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes

Have you ever had any serious illness not checked above? If yes, describe:

Important!!! For Women Only

Are you pregnant? No Yes

Are you trying to get pregnant? No Yes

Are you nursing? No Yes

Are you taking oral contraceptives? No Yes

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals.

X _____
Signature of Patient or Guardian Date

I hereby authorize this office to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents through my employment. I hereby authorize payment of dental benefits otherwise payable to me, directly to this dental office. This 'signature on file' will be valid from this date and shall expire one year from today's date or unless I cancel the authorization through written notice to this office. A photocopy of this document may act as an original.

X _____
'Signature on file' of Patient or Guardian Date

Financial Policy

To keep our fees as low as possible, payment is expected on the date services are initiated. In some instances, we may ask that you prepay for your dental services to reserve special appointment times. We will provide you with a written estimate of your financial investment prior to any treatment being rendered. Fees quoted are good for 90 days from the date of the estimate. Please indicate the method you intend to use to pay for your dental treatment, including your co-payment:

Credit Card Cash Check Care Credit I would like to know more about my financial options

Special Information About Dental Insurance

We want to help you maximize your insurance benefits. Please remember, dental insurance does not always cover the cost of your treatment as anticipated. While dental/medical costs have increased exponentially in the past 10 years, dental insurance benefits have remained relatively unchanged over the past 40 years. As a courtesy, we will attempt to obtain an *estimate* of your dental insurance assistance prior to services being rendered and will provide you with a copy of your estimate. This will give you a generalized overview of your coverage. Please keep in mind that there are hundreds of dental insurance plans available and every one has different contract exclusions, alternate benefit clauses, frequency limitations, and/or usual and customary guidelines. Because of this, we can never guarantee claim payments. We do not allow insurance companies to dictate the course of treatment for our patients. Rest assured that we will recommend a treatment plan that is appropriate for your diagnosis regardless of what your insurance might or might not reimburse.

We are more than happy to request that your insurance benefits be sent directly to our office with your consent and if your plan offers this service. Unfortunately, there are a few carriers that will not send payment to the provider, even when we request that they do so. Delta Dental is one such plan. In this instance, we ask that you pay in full for services at which time we will handle the paperwork to see that you receive direct reimbursement from your carrier in a prompt manner.

Dental insurance is a contract between the patient, the insurance company, and the employer and we are not a party in that contract. Ultimately, the patient is financially responsible for treatment costs. If insurance fails to pay benefits as anticipated, our financial policy requires that the remaining balance be paid in full within 25 days of the final billing date. In addition, any insurance claim aged over 60 days that has not been paid or denied by the insurance carrier will become the patient's responsibility. We reserve the right to add a service charge to overdue accounts. The service charge will be a minimum of \$5.00 and a maximum of \$25.00 each month.

By signing below, I acknowledge that I understand and agree to Huckabee Dental's financial policies. Even if I do not currently have dental insurance, I understand that the "Special Information About Dental Insurance" section applies to me should I obtain dental insurance in the future. I will promptly notify the business office with any changes in my dental insurance coverage and/or eligibility status. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

X _____

Signature of Patient or Guardian

Date