Patient Registration

Today's Date: ____________

First Name ____________________ MI ____ Last Name ____________________ Sex: ☐ Male ☐ Female

Birth Date ______________ Age _______ SSN ______________________

Cell ____________________ Home ______________________ Email __________________________

Street ________________________________ City ______________________ State ______ Zip ______

Dentist ____________________ Orthodontist ______________________ Pharmacy________________

Pharmacy Phone Number______________ ☐ Married ☐ Divorced ☐ Single ☐ Widow ☐ Legally Separated

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 _________

Employer _______________________________________ Bus Tel. ______________________________

Primary Dental Insurance Company:

Ins Co. Name _____________________________

ID# ____________________ Group __________

Address _________________________________

City _____________ State _______ Zip _______

Phone ___________________

Insured Party ____________________________

Relation _______________ Date of Birth ______

Employer _______________________________

Primary Medical Insurance Company:

Ins. Co. Name ____________________________

ID# ____________________ Group _________

Address _______________________________

City _____________ State ______ Zip ______

Phone ____________________

Insured Party ____________________________

Relation ______________ Date of Birth _______

Employer _______________________________

Secondary Dental Insurance Company:

Ins Co. Name _____________________________

ID# ____________________ Group __________

Address _________________________________

City _____________ State _______ Zip _______

Phone ___________________

Insured Party ____________________________

Relation _______________ Date of Birth ______

Employer _______________________________

Secondary Dental Insurance Company:

Ins. Co. Name ____________________________

ID# ____________________ Group _________

Address _______________________________

City _____________ State ______ Zip ______

Phone ____________________

Insured Party ____________________________

Relation ______________ Date of Birth _______

Employer _______________________________

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	☐	☐

Women only: *(Questions 6-9)*

	Yes	No		Yes	No
6. Is there a possibility of pregnancy	☐	☐	8. Are you nursing	☐	☐
7. Expected delivery date ____________________			9. Are you taking birth control	☐	☐

Have you had or do you currently have:

	Yes	No		Yes	No
10. Damaged heart valves/ Mitral Valve Prolapse	☐	☐	32. Fainting spells	☐	☐
11. Heart murmur	☐	☐	33. Convulsions/ Epilepsy	☐	☐
12. High blood pressure	☐	☐	34. Stroke	☐	☐
13. Low blood pressure	☐	☐	35. Thyroid trouble	☐	☐
14. Chest pain/ angina	☐	☐	36. Diabetes	☐	☐
15. Heart Attack(s)	☐	☐	37. Low blood sugar	☐	☐
16. Irregular heart beat	☐	☐	38. Arthritis/joint disease	☐	☐
17. Cardiac pacemaker/ stent	☐	☐	39. Osteoporosis/ osteopenia	☐	☐
18. Heart Surgery	☐	☐	40. Stomach ulcers/ acid reflux	☐	☐
19. Pnemonia, bronchitis, chronic cough	☐	☐	41. Contagious Disease	☐	☐
20. Asthma	☐	☐	42. Problems with immune system possibly from medication/ surgery	☐	☐
21. Sleep apnea/ CPAP/ snoring	☐	☐	43. Delay in healing	☐	☐
22. Difficulty breathing/ lung trouble	☐	☐	44. A tumor or growth	☐	☐
23. Difficulty breathing/ lung trouble	☐	☐	45. Radiation to the head or neck	☐	☐
24. Smoke or use chewing tobacco	☐	☐	46. Cancer/ radiation/ Chemotherapy	☐	☐
25. Blood transfusion	☐	☐	47. Eye disease/ glaucoma	☐	☐
26. Blood disorder such as anemia	☐	☐	48. Mental health problems/ anxiety Depression	☐	☐
27. Bruise easily	☐	☐			
28. Bleeding tendency/ abnormal bleed	☐	☐	49. A removable dental appliance	☐	☐
29. Hepatitis, jaundice, or liver disease	☐	☐	50. Pain or clicking of the jaw	☐	☐
30. Kidney trouble/ disease	☐	☐	51. History of drug/ alcohol abuse	☐	☐
31. Are you on dialysis?	☐	☐	52. Do you play an wind instrument	☐	☐

	Yes	No
53. Blood thinners (Coumadin, Plavix)	☐	☐
54. Diet pills	☐	☐
55. Are you taking or have you ever Taken bone density meds, RANKL Inhibitors or bisphosphonates (Fosamax, Actonel, etc.) in the Past 12 years?	☐	☐
56. Marijuana or other "street drug"	☐	☐

57. Please list all medications you are taking:

Medication	Dosage

58. 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)

	Yes	No
59. Local anesthetic (numbing meds.)	☐	☐
60. Antibiotics (Penicillin, Sulfa, etc.)	☐	☐
61. Codeine or other narcotics	☐	☐
62. Latex	☐	☐
63. Eggs or other food allergies	☐	☐
64. Nickel or other metals	☐	☐

65. Please list all known allergies:

66. Is there any condition concerning your health That the doctor should be told about? __________

If yes, describe ______________________

67. Is this visit related to an accident? ______________

If yes, what type of accident? ______________

Date of injury ______________________

68. Do you wish to speak to the doctor privately?

☐ Yes ☐ No

____

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

2334 GAUSE BLVD. EAST
SLIDELL, LA 70461
(985) 641-2030

363 LAKEVIEW CT.
COVINGTON, LA 70433
1-800-460-1091

PONTCHARTRAIN ORAL SURGERY

DR. C. BRADLEY DICKERSON

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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)

____

____

____

© 2002 American Dental Association

All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

2334 GAUSE BLVD. EAST
SLIDELL, LA 70461
(985) 641-2030

363 LAKEVIEW CT.
COVINGTON, LA 70433
1-800-460-1091