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:

Ins. Co. Name: _____

ID#: _____ Grp #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Tel: _____

Insured Party: _____

Relation: _____ Date of Birth: _____

Primary Medical Insurance Company:

Ins. Co. Name: _____

ID#: _____ Grp #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Tel: _____

Insured Party: _____

Relation: _____ Date of Birth: _____

Secondary Dental Insurance Company:

Ins. Co. Name: _____

ID#: _____ Grp #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Tel: _____

Insured Party: _____

Relation: _____ Date of Birth: _____

Secondary Medical Insurance Company:

Ins. Co. Name: _____

ID#: _____ Grp #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Tel: _____

Insured Party: _____

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?.....	☐	☐	11. Are you nursing?.....	☐	☐
12. Expected delivery date: _____			13. Are you taking birth control pills?...	☐	☐

Have you had or do you currently have:

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

Have you had or do you currently have:	Yes	No
48. Blood thinners (Coumadin, Plavix, etc.)	☐	☐
49. Diet Pills	☐	☐
50. Are you taking or have you taken bone density medications, RANKL inhibitors or bisphosphonates (Fosamax, Boniva, Actonel, etc.) in the past 12 years	☐	☐
51. Marijuana or "street drug"	☐	☐

52. Please list all medications you are currently taking:

Medication	Dosage

Are you allergic, or had a reaction to:	Yes	No
54. Local anesthetic (numbing meds.)	☐	☐
55. Antibiotics (Penicillin, Sulfa, etc.)	☐	☐
56. Codeine or other narcotics	☐	☐
57. Latex	☐	☐
58. Eggs or other food allergies	☐	☐
59. Nickel or other metals	☐	☐

60. List all known allergies:

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

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)

_____

_____

_____

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