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: ______________________________________
MM/DD/YY Home Cell

DRIVERS LICENSE# ____________________ SOCIAL SECURITY# ________________________

PLACE OF EMPLOYMENT: ______________________ WORK # ___________________________

Has any member of your family ever been treated in our office? □ Yes □ No If yes, who?__________________

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

□ Newspaper □ I saw your sign □ Yellow Pages □ Magazine □ Direct Mail □ Internet
□ Acquaintance: ________________________ □ Another Dr.:__________________________

Insured Information	Responsible/Billing Party Information
Relation to Patient: □ Self □ Spouse □ Parent/Guardian □ Other	Relation to Patient: □ Self □ Spouse □ Parent/Guardian □ Other
Last First MI	Last First MI
Street Address City ST Zip	Street Address City ST Zip
Home/Cell Telephone # Birth Date (MM/DD/YY)	Home Telephone # Cell Telephone #
Employer Dental Insurance Company	Email Address Birth Date (MM/DD/YY)
Insured Social Security # or Insured ID# (if different than social)	Drivers License # Social Security #
Insurance Mailing Address	Employer Work Telephone #
Ins Phone Number Group/Plan Number	

PERSON TO CONTACT INCASE OF EMERGENCY
Outside of immediate family / household

Name: ________________________________Telephone Number: ______________________

May we leave messages announcing our office name in regards to appointments, treatment, and/or insurance/financials on your voicemail? □YES □NO □YES, with exceptions:______________________

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 Please list (use back of this form if needed):________

____

Are you allergic to any of the following:

Aspirin	□ No □ Yes	Acrylic	□ No □ Yes	Penicillin	□ No □ Yes
Latex Rubber	□ No □ Yes	Codeine	□ No □ Yes	Other:________________________	

Do you have any of the following:

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

e 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

Huckabee Dental

Financial and Insurance Policy

Our primary responsibility to you is to provide quality dental care. To maintain this standard of care, we believe that it is in the best interest of everyone to establish a patient account policy up front to avoid any misunderstandings. We will provide you with a written estimate of your financial investment prior to any treatment being rendered. Treatment estimates quoted are good for 90 days from the date of the estimate.

1. **PAYMENT IS EXPECTED ON THE DATE OF SERVICE**…In some instances, we may ask that you prepay for your dental services to reserve special appointment dates and/or times. 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

2. **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. 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 instances in which we cannot accept assignment of benefit. Some carriers will not send payment to the provider, even when we request that they do so. There are also insurance plans that are set up to reimburse on a "fee schedule", rendering estimates of coverage impossible. Finally, COBRA insurance, which is month to month insurance, pays benefits totally dependent upon receiving a premium by a set date. In these three instances, 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.

Many insurance plans have frequency limitations, alternate benefit clauses, and other exclusions that ***may limit your coverage***. Ultimately, the patient is financially responsible for treatment costs. As a courtesy, we will attempt to obtain an *estimate* of your dental insurance assistance prior to services being rendered. If insurance does not pay 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.

3. **ADDITIONAL ACCOUNT CHARGES**…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. A charge of $25 will be applied to all returned checks. We require that returned checks and fees be cleared by cash, certified funds, or credit card.

4. **DIVORCED PARENTS and THIRD PARTY BILLING**…It is the policy of this office that the parent/guardian accompanying the child to the visit be held responsible for treatment consents and all charges incurred; regardless of insurance, divorce decrees, or financial situations. We do not bill to any other third parties and we do not accept assignment of benefits from secondary insurance.

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 "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 phone numbers, mailing address,and 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 □ Parent/Guardian Date

PATIENT CONSENT TO TREATMENT

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

PREVENTATIVE CARE: I understand that the long term success of treatment and status of my oral condition depends on my efforts at maintaining proper oral hygiene (i.e. brushing and flossing) and my diligence with regular recall visits. I further understand that failure to abide by recare recommendations set by Timothy M. Huckabee, DDS, PC will negate any guarantee that may exist on restorative and/or prosthetic services provided by the dentists.

DIAGNOSTIC RADIOGRAPHS: I understand that Huckabee Dental utilizes intra-oral and extra-oral digital radiograph to assist in obtaining an accurate diagnosis of dental condition(s). I authorize the performance of x-rays that the dentist considers necessary or advisable in the course of my examination.

PEDODONTICS (CHILD DENTISTRY) if applicable: I understand that the following procedures are routinely used at this facility, as well as being accepted procedures in the dental profession.
A. POSITIVE REINFORCEMENT - Rewarding the child who portrays desirable behavior by use of compliments, praise, a pat or hug, and/or token objects or toys.
B. VOICE CONTROL - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT - Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm.
D. NITROUS OXIDE AND/OR ORAL SEDATION - Nitrous oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use, the parent/or guardian must understand that the child should not eat or drink for a period of eight hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

LOCAL ANESTHETIC: I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that I may inadvertently bite my lip causing possible injury. I understand the need to return to the office, for evaluation, if swelling and/or pain does not go away after a sufficient period of time.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT ANY PROPOSED DIAGNOSTIC, PREVENTATIVE, AND/OR PERIODONTAL TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS. **(Initial Here)_________**

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THIS CONSENT, AND AGREE TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION. **(Initial Here)_________**

I UNDERSTAND THAT THIS FACILITY PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS. **(Initial Here)_________**

I HAVE BEEN OFFERED AND/OR GIVEN A COPY OF THIS OFFICES PRIVACY PRACTICES FOR THE PROTECTION OF MY PERSONAL INFORMATION IN ACCORDANCE WITH GOVERNMENT HIPAA REGULATIONS. **(Initial Here)_________**

Signature:____ Date:____________
Relationship to Patient:____________________

IN FURTHER CONSIDERATION FOR THIS, DOCTOR AGREES TO THE SAME STIPULATIONS.

Huckabee Dental
http://www.dfwdental.com