MAD RIVER
FAMILY DENTAL

DAVID C. HICKEY, DDS
7544 Dayton Springfield Rd.
Fairborn, Ohio 45324
madriverfamilydental.com

PATIENT REGISTRATION

Patient Name: _____
Last First MI Preferred

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Birth Date: _____ SSN: _____ Gender: Male Female _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Employer: _____

RESPONSIBLE PARTY, IF DIFFERENT

Name: _____
Last First MI Preferred

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Birth Date: _____ SSN: _____ Gender: Male Female _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Subscriber's Name: _____
Last First MI

Insured's Birth Date: _____ Subscriber ID: _____ Group: _____

Employer Name: _____

Relationship to Subscriber: Self Spouse Child Other

Insurance Plan Name & Address: _____

Secondary Insurance

Subscriber's Name: _____
Last First MI

Insured's Birth Date: _____ Subscriber ID: _____ Group: _____

Employer Name: _____

Relationship to Subscriber: Self Spouse Child Other

Insurance Plan Name & Address: _____

MEDICAL HISTORY

Major Operations and Hospitalizations in the last 10 years: _____

_____

_____

_____

Medications and Dietary Supplements: *(including aspirin or other blood thinners. Attach a separate sheet if necessary.)*

_____

_____

_____

_____

Allergies: Penicillin ☐ Sulfa ☐ Clindamycin ☐ Codeine ☐ Metal ☐ Latex ☐

Other Allergies (including foods): _____

Please mark if you have or have had any of the following medical conditions:

- ☐ Autoimmune Disorder
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Disease
- ☐ Dementia
- ☐ Diabetes, Type I or Type II
- ☐ Dizziness/Vertigo
- ☐ Drug Abuse
- ☐ Emphysema or COPD
- ☐ Epilepsy/Seizure
- ☐ Excessive Bleeding
- ☐ GERD / Acid Reflux
- ☐ Head/Neck Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Hemophilia or Clotting Issue
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV or AIDS
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat/A-Fib
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease/Cirrhosis
- ☐ Mobility Problems
- ☐ Mitral Valve Prolapse
- ☐ Opioid Use
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Radiation
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Stroke or TIA
- ☐ Thyroid Problems
- ☐ Vision Problems

Primary Care Physician: _____

Specialist (Cardiologist, Neurologist, or Orthopedist): _____

Preferred Pharmacy:_____

Patient Name: _____ Date _____

DENTAL HISTORY

Please mark if you have or have had any of the following dental conditions so we may better serve you:

- ☐ Bleeding Gums
- ☐ Receding Gums
- ☐ Shifting Teeth
- ☐ Bad Breath
- ☐ Dry Mouth
- ☐ Loose Teeth
- ☐ Esthetic Concerns
- ☐ Speech Concerns
- ☐ Other: _____
- ☐ Clenching the Jaw
- ☐ Grinding of Teeth
- ☐ Jaw Pain
- ☐ Teeth Pain
- ☐ Teeth Sensitivity
- ☐ Cold Sores/Fever Blisters
- ☐ Oral Cancer
- ☐ Difficulty Numbing
- ☐ Broken Teeth
- ☐ Missing Teeth
- ☐ Poor Fitting Dentures
- ☐ Bite Doesn't Feel Right
- ☐ Problems Chewing or Eating
- ☐ Sinus Trouble
- ☐ Traumatic Dental Experience
- ☐ Tobacco Use

FINANCIAL POLICY

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. Parents who are not accompanying their children to their appointments are responsible for making payment arrangements. Restorative treatments that take multiple appointments (such as crowns or dentures) allow you to pay in two installments with the final payment due at prosthesis delivery.

Payment Options include: cash, check, Visa, MasterCard, Discover, American Express, and CareCredit (a third-party financing company).

If you have insurance, know that YOU are responsible for the ESTIMATED co-pays at the time of service. We will submit to insurance as a courtesy to you; however, any amount that your insurance declines to pay is still your responsibility. If your insurance pays more than we estimated, any resulting account credit can be used toward future treatment or refunded to you.

BROKEN APPOINTMENT POLICY

We understand that there may be times when you must miss an appointment due to emergencies or obligations for work or family. **If you need to cancel your appointment, please call us at (937) 864-2341 with a MINIMUM 24 hours notice in advance. You may also text the office when we text you to confirm your appointment.**

When you schedule an appointment with us, we reserve that time exclusively for you. If you do not show up for your appointment, or you cancel without sufficient notice, it prevents another patient from being seen for needed treatment. We will count this as a broken appointment. Additionally, if you are over 15 minutes late to your appointment, we may have to reschedule you because of time constraints, and this counts as a broken appointment as well. **Broken appointments will be charged a broken appointment fee. This fee is currently $50 but may be subject to change.**

We reserve the right to dismiss a patient from the practice if that patient has missed three appointments in a one year period. For "new" patients that have not yet established care, we reserve the right to not reschedule you if you do not show up to your first appointment. Thank you for your cooperation.

GENERAL CONSENT TO RECEIVE DENTAL SERVICES

This is a general treatment consent that is required for you to receive any dental services at this office. This general consent includes common, routine dental examination and treatment, including but not limited to:

1. Examination and x-rays of the mouth (including the teeth, tongue, throat, cheeks, probing of the gums, etc.)
2. Cleaning the teeth and hygiene instruction
3. Numbing the teeth or gums as necessary to provide comfortable treatment
4. Standard fillings and crowns that may be needed from time to time, according to the treatment plan
5. Other procedures according to the treatment plan agreed upon by the patient

More extensive or more invasive treatment options may have an additional consent required.

Our office welcomes patients of all ages, including children. For new patients who are under the age of 18, the minor patient MUST be accompanied by a parent or legal guardian for their first appointment. For any future appointments, the minor may be accompanied by the individuals that I designate below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

HIPAA / PRIVACY POLICY

In signing this HIPAA Patient Acknowledgment, you acknowledge that this office may recommend products or services to promote your improved oral health. Under the current HIPAA Omnibus Rules, we provide you this information with your knowledge and consent.

We restrict who can see your Protected Health Information (PHI). PHI includes but is not limited to chart notes, intraoral and extraoral images, radiographs, models, procedure history, referrals made, and billing records. We require your approval of our HIPAA policy in order to release your information to insurances to request payment, and to other people designated here:

Name: _____ **Relationship:** _____

You acknowledge that you have received, or were offered to receive, a copy of the current effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. My signature also serves as a PHI Document Release should I request treatment or radiographs to be sent to other dentists or facilities.

REQUIRED SIGNATURE

I hereby agree to the policies outlined above, including the financial policy, broken appointment policy, general consent to receive dental services, and HIPAA/privacy policy. The above information regarding my medical and dental history is as complete and accurate as possible. Signing this form does not mean that I am obligated to have the recommended treatment provided to me. I understand that I may refuse treatment at any time before the treatment is provided. I am, or my parent, legal guardian or representative is, signing this patient registration packet. I understand and give my consent to have examination and treatment at this office.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____