OZARK FAMILY DENTAL

DR. ALLAN RICE

REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Last Name:_____ First:_____ Middle:_____
□Mr. □Mrs. □ Miss □ Ms.
Marital Status: Single Married Divorced Separated Widowed
Birth Date: _____ Age:_____ Sex: □ M □ F
Social Security #: _____
Phone Numbers: Home: _____ Cell: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Employer: _____ Employer Phone #: _____
Occupation: _____
Email Address: _____Receive Email: □YES □NO or Text □YES □NO

DENTAL CARE INFORMATION

General/Restorative Dentist: _____
Date of Last Cleaning: _____
Reason for Office Visit: _____
What is your daily dental hygiene routine? □ Brush □ Floss □ Mouth Rinse
Date of last Dental Exam: _____
Date of last Dental X-rays: _____
Preferred Pharmacy: _____ Location/Phone#: _____

DENTAL INSURANCE INFORMATION

Insurance Company Name:_____
Subscriber's Name: _____ Subscriber's SS#: _____
Subscriber's Employer: _____ Occupation:_____
Employer Address: _____ Phone #:_____
Subscriber's Birth Date:_____ Group #:_____ Policy ID#:_____
Patient's Relationship to Subscriber □ Self □ Spouse □ Child □ Other
Name of Secondary Insurance: _____
Subscriber's Name: _____ Group #: _____ Policy #:_____
Patient's Relationship to Subscriber: □ Self □Spouse □ Child □ Other

Patient Signature: _____
Date: _____

OZARK FAMILY DENTAL

Your Signature is necessary for us to:
• PROCESS ALL INSURANCE CLAIMS
• ENSURE PAYMENT FOR SERVICES RENDERED
• RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
• RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES WHEN
NECESSARY FOR YOUR TREATMENT.
• PROVIDE EXCELLENT DIAGNOSTIC AND PREVENTIVE CARE

I hereby authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits, to which I am entitled to Dr. J. Allan Rice. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment to be considered as valid as the original.

Patient Name: _____
Patient or Guardian Signature:
_____
Date: _____

HEALTH HISTORY FORM

YES / NO

___ ___ Do your gums bleed when you brush?
___ ___ Past or present orthodontics
___ ___ Sensitive to hot or cold
___ ___ Past Periodontal (Gum) Treatment
___ ___ Wear removable dental appliances
___ ___ AIDS or HIV infection
___ ___ Asthma
___ ___ High blood pressure
___ ___ Low blood pressure
___ ___ Do you have a Sleep Disorder?
___ ___ Do you own a CPAP machine?
If so, how often do you use this machine: _____
___ ___ Rapid weight loss
___ ___ Headache/Migraines
___ ___ Kidney Disease
___ ___ Angina
___ ___ Post-transplant patient---
Specify Transplanted Organ:
_____
___ ___ Lung Disease
___ ___ Liver Disease
___ ___ Chronic pain
----Specify Location:
_____
___ ___ Artificial Valve
___ ___ Emphysema
___ ___ Stomach Ulcers
___ ___ Stroke
___ ___ TB
___ ___ Pacemaker
___ ___ Malnutrition
___ ___ Problems with chewing
___ ___ Pregnancy
___ ___ History of Heart Attack(s)
___ ___ Osteoporosis
___ ___ Diabetes Type I Type II
___ ___ Autoimmune Disease

YES / NO

___ ___ Cancer----
Chemotherapy Radiation
___ ___ Artificial Joint
___ ___ Eating Disorder
___ ___ Gastrointestinal Disease
___ ___ Acid Reflux
___ ___ Thyroid problems
___ ___ Recurrent infection--
Specify Type of Infection:
_____
___ ___ Persistent Heartburn
___ ___ Dry Mouth
___ ___ Oral pain or discomfort
___ ___ Earaches or Neck pain
___ ___ Jaw clicking/popping
___ ___ Jaw Discomfort
___ ___ TMJ Dysfunction
___ ___ Brux or Grind your teeth
___ ___ Sores or Ulcers in your mouth
___ ___ Gum Inflammation/Swelling
___ ___ Tobacco use----
Product _____
How long? _____

Allergies: None Novocain
Latex/tape Demerol
Antibiotics Other: _____

OZARK FAMILY DENTAL

IN CASE OF EMERGENCY

Name of Local friend or Relative:
_____

Relationship to Patient:
_____

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

Patient Signature:
_____

Date: _____

HIPPA CONSENT

I give consent for the family members listed below to receive information concerning my Medical/Dental records at Ozark Family Dental to include insurance information, financial information, making and cancelling appointments on my behalf.

Patient Signature:
_____

Date: _____

Payment in full is due at the time of service. We accept Cash, Checks, Debit Cards, all major credit cards and Care Credit as forms of payment. You will be charged a $35.00 bank fee for any returned checks for any reason.

To make sure that every patient gets individual attention, we set aside dedicated time for each appointment. If you find it necessary to cancel an appointment, we request that you provide the dental office with 24 hours' notice.

If appropriate notice is not given, you may be charged $35 for a broken or cancelled appointment. This fee is subject to change without notice.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ozark Family Dental or my insurance company to release any information required to process my claims.
By my signature below, I indicate that I have been informed of and agree to the privacy practices of Ozark Family Dental.

Patient Signature:
_____

Date: _____

Ozark Family Dental

RELEASE OF MEDICAL INFORMATION & FINANCIAL POLICY

Your medical information is personal and we are committed to protect this information. We create a record of the care and services you receive at our office and these records are used to provide you with quality care and to comply with certain legal requirements. This Notice applies to all the records of your care generated by this office whether made by your general dentist or one of our employees.
In order to release your personal information, including lab results, test results or financial matters, to anyone other than yourself, please read and sign in designated area(s) below.

The following describes the different ways that your information may be used or disclosed by this office:
For Treatment: We use medical information about you to provide you with medical treatment and services. We may disclose medical info about you to your referring dentist, doctors, nurses, technicians, and other office personnel who are involved in providing you treatment.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. I grant permission to Dr. J. Allan Rice, Ozark Family Dental and its employees and/or agents the right to contact me via home phone, work phone, cell phone, email or any other means I have provided in order to notify me of any future appointments, changed appointments.

For Insurance and Collections: Our office does participate with some insurance companies as a provider, and we will file your claims with your insurance company and assist you with any supplemental forms, if we are given the necessary information at the time of your initial service. Your insurance is a contract between you (the Subscriber), your employer and the insurance company; we are not a party to that contract. I hereby make assignment of all dental, disability, surgical, medical and major insurance benefits to Dr. J. Allan Rice to release any medical information necessary to execute an assignment of benefits. I understand that regardless of any insurance coverage, I am personally responsible for all charges to this account. I further agree in the event of non-payment, to accept the collection agency fees, and/or court cost and reasonable legal fees should this be necessary. The collection agency fees (33.33) will be added to all delinquent accounts at the time they are placed with a collection agency. If you provide more than one-half of the support for a child or other dependent, all or part of your income is exempt from garnishment under Alabama law, by signing below I waive this protection. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I agree, in order for Dr. J. Allan Rice, D.MD. and/or agents may contact you by telephone at any telephone associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text message or emails, using any email address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law.
I have read and understand the above and agree to the conditions listed above.

Patient Signature:
_____

Date: _____