Stubblefield Dental Clinic

508 Azalea Drive
Post Office Box 964
Oxford, MS. 38655
Phone: (662) 236-5858

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS # _____ Prev. Visit _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile)

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Employment

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

I prefer to be contacted by: ☐ Cell ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number, and relationship below:

_____

Stubblefield Dental Clinic

Primary Dental Insurance

Name of Insured: Last | First | MI | Preferred

Insured's Birth Date: | ID # | Group #

Insured's Address:

City | State | Zip Code

Insured's Employer Name:

Employer's Address:

City | State | Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City | State | Zip Code

Insurance Authorization

☐ By checking this box,

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

_____

Signature

Stubblefield Dental Clinic

Patient Name: Last | First | MI | Preferred

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Allergies
- ☐ *High Blood Pressure
- ☐ Allergy-Codeine
- ☐ Alzheimer's/Dementia
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Dizziness/Fainting
- ☐ Gastric/Acid Reflux
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Other
- ☐ Respiratory Problems
- ☐ STD/HPV
- ☐ *Diabetes
- ☐ *MVP
- ☐ Allergy-Latex
- ☐ Anemia
- ☐ Asthma/COPD
- ☐ Blood Thinners
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Head/Neck Injuries
- ☐ Hepatitis A/B/C
- ☐ Kidney Disease
- ☐ Nervous Disorders
- ☐ Pacemaker/Stents
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ *Heart Murmur
- ☐ *Rheumatic Fever
- ☐ Allergy-Penicillin
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Growths/Tumors
- ☐ Heart Attack/Stroke
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Radiation/Chemo
- ☐ Sinus
- ☐ Ulcers

- ☐ Pregnant/Planning Pregnancy/Nursing
- ☐ Headaches/Migraines
- ☐ Taking No Medications

Please clarify the conditions or alerts selected above including due date if pregnant:

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HIPPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revolved, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Stubblefield Dental Clinic. I hereby authorize, as indicated by my signature below, Stubblefield Dental Clinic to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form. I understand that I have the right to review the Notice of Privacy prior to signing this authorization.

Please list authorized person with whom we may discuss your Protected Health Information (PHI). Please notify us in writing if you desire to remove/ add a name from this list in the future.

1. _____Relationship:_____Date_____(circle): added / removed
2. _____Relationship:_____Date_____(circle): added / removed

Stubblefield Dental Clinic

Dental Insurance

I authorize the practice to release to staff, hospitals, healthcare service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment. I authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

PATIENT CONSENT FOR SERVICES AND FINANCIAL POLICY

I authorize Stubblefield Dental Clinic to perform all recommended treatment. I authorize the practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "diagnostic material") as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payors and/or other health professionals. I authorized the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be paid in full before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that a NSF fee of $100 will be added to my account for any returned check. I understand that any fee estimate for dental care can only be extended for a period of six months from the date of the patient examination.

I have reviewed the above information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Stubblefield Dental Clinic to help determine appropriate and healthful dental treatment. If there is any change I will inform Stubblefield Dental Clinic. I consent to communication via text message, email, mail and phone calls using the information that I have provided. I understand that I have the right to request that we communicate with you by alternative means or to alternative locations and this shall be requested in writing. Request must specify the alternative means or location. I have reviewed the privacy rule consent agreement and the HIPAA Acknowledgement. I authorize my insurance company to pay Stubblefield Dental Clinic all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the release of all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____Date: _____

If patient is a child, please provide the parental or legal guardian's consent:

Signature: _____Relationship:_____Date:_____

NOTE(MINORS): The parent or legal guardian must complete this form for a minor (under age of 18), provide consent for dental treatment and accompany the child during each dental visit. If the parent or legal guardian consented to treatment in advance, an authorized individual named on Page may bring the child. Treatment will not be provided for unattended children.