MAD RIVER
FAMILY DENTAL

PATIENT INFORMATION

Patient Name:____ Date:________________
Last First MI

Preferred Name:________________________________ Gender: Male ☐ Female ☐

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

Social Security#__________________________ Birthdate ______/______/______

Address ____

City ______________________________ State ________________ Zip __________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email: __________________________ Which is best to reach you at? ________________

SPOUSE OR RESPONSIBLE PARTY

Name:____ Gender: Male ☐ Female ☐
Last First MI

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

Social Security#__________________________ Birthdate ______/______/______

Address ____

City ______________________________ State ________________ Zip __________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Which is best to reach you at? ________________

INSURANCE INFORMATION

Primary Insurance

Subscriber's Name:____
Last First MI

Insured's Birthdate ______/______/______ ID#______________ Group#______________

Employer's Name:______________________ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name & Address:____

Insurance Plan Phone # ______________________

Secondary Insurance

Subscriber's Name:____
Last First MI

Insured's Birthdate ______/______/______ ID#______________ Group#______________

Employer's Name:______________________ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name & Address:____

Insurance Plan Phone # ______________________

HEALTH HISTORY

Major Operations or Hospitalizations:____________________

Please list any **MEDICATIONS** you are taking:____________________

____

____

Are you allergic to any of the following:

☐ Aspirin ☐ Metal ☐ Penicillin ☐ Latex ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic ☐ Local Anesthetics

Other Allergies (Including Food Allergies):____________________

Have you been diagnosed with Sleep Apnea? If yes, do you wear an appliance?____________________

PLEASE MARK IF YOU HAVE OR HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS:

- ☐ AIDS/HIV POSITIVE
- ☐ ALZHEIMER'S
- ☐ ANAPHYLAXIS
- ☐ ANEMIA
- ☐ ANGINA
- ☐ ARTHRITIS/GOUT
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINT
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ BLOOD TRANSFUSION
- ☐ BREATHING PROBLEMS
- ☐ BRUISE EASILY
- ☐ CANCER
- ☐ CHEMOTHERAPY/RADIATION
- ☐ COLD SORES/FEVER BLISTERS
- ☐ CONGENITAL HEART DISORDERS
- ☐ CORTISONE
- ☐ DIABETES
- ☐ DRUG ADDICTION
- ☐ EMPHYSEMA
- ☐ EPILEPSY/SEIZURES
- ☐ EXCESSIVE BLEEDING
- ☐ EXCESSIVE THIRST
- ☐ FAINTING SPELLS/DIZZINESS
- ☐ FREQUENT COUGH
- ☐ FREQUENT HEADACHES
- ☐ GLAUCOMA
- ☐ HEAD/NECK INJURIES
- ☐ HEART ATTACK/FAILURE
- ☐ HEART MURMUR
- ☐ HEART PACEMAKER
- ☐ HEART TROUBLE/DISEASE
- ☐ HEMOPHILIA
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIVES OR RASH
- ☐ HYPOGLYCEMIA
- ☐ IRREGULAR HEARTBEAT
- ☐ KIDNEY PROBLEMS
- ☐ LEUKEMIA
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ LUNG DISEASE
- ☐ LYMES DISEASE
- ☐ LUPUS
- ☐ MITRAL VALVE PROLAPSE
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATISM
- ☐ SCARLET FEVER
- ☐ SHINGLES
- ☐ SICKLE CELL DISEASE
- ☐ SINUS TROUBLE
- ☐ SPECIAL DIET
- ☐ SPINA BIFIDA
- ☐ STOMACH/INTESTINAL DISEASE
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ TOBACCO USE
- ☐ TONSILLITIS

Name of Physician:____________________ **Pharmacy:**____________________

Print Name:____________________ **Signature:**____________________

Relationship to Patient:____________________ **Date:**____________________

MAD RIVER
FAMILY DENTAL

DAVID C. HICKEY, DDS
7544 Dayton Springfield Rd.
Fairborn, Ohio 45324
Phone: 937-864-2341
madriverfamilydental.com

FINANCIAL AGREEMENT

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.

Payment Options:

1. Cash
2. Check
3. Mastercard
4. Visa
5. Discover
6. American Express
7. CareCredit

Patient with Insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of service.

Parents not accompanying their children are financially responsible for payment.

Records can be viewed at any time.

We submit to insurance as a courtesy although, your account balance is your responsibility.

I, ____, agree to these financial terms.

Signature:_______________________________________ Date:____

DAVID C. HICKEY, DDS
7544 Dayton Springfield Rd.
Fairborn, Ohio 45324
Phone: 937-864-2341
madriverfamilydental.com

BROKEN APPOINTMENT POLICY

Our goal is to provide quality dental care to all of our patients. In order to do so, we have implemented the following cancellation policy at our office. This policy allows us to better use available appointments for our patients in need of dental care.

When you schedule an appointment, we reserve that time exclusively for you. If you do not show up for your appointment, it prevents another patient from being seen for needed treatment.

HOW TO CANCEL YOUR APPOINTMENT
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** at least 24 hours notice in advance. If necessary, you may leave a message with your name and phone number. A receptionist will get back with you as soon as possible.

Additionally, if you are 15 minutes past your scheduled time, we may have to reschedule your appointment.

CANCELLATION FEE
If you miss a scheduled appointment without informing us within 24 hours, we will apply a $35 fee to your account for each missed appointment.

DISMISSAL
We reserve the option to dismiss you as a patient if you miss three (3) appointments in a one-year period without a 24 hour notice under this policy.

Patient Name:______________________________

Signature/Parent/Guardian:______________________________

Date:______________________________

DAVID C. HICKEY, DDS
7544 Dayton Springfield Rd.
Fairborn, Ohio 45324
Phone: 937-864-2341
madriverfamilydental.com

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date:________________________________ Patient Name:________________________________

How do you want to be addressed when summoned from reception area:

☐ FIRST NAME ONLY ☐ PROPER SURNAME ☐ OTHER ________________________

Please list any other parties who are actively involved in your health care and who can have access to your health information:
(This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name:________________________________ Relationship:________________________________

Name:________________________________ Relationship:________________________________

I authorize contact from this office to confirm my appointments, treatment & billing information via:

☐ CELL PHONE CONFIRMATION ☐ EMAIL CONFIRMATION ☐ TEXT MESSAGE TO MY CELL PHONE

☐ WORK PHONE CONFIRMATION ☐ HOME PHONE CONFIRMATION ☐ ANY OF THE ABOVE

I authorize information about my health can be conveyed via:

☐ CELL PHONE CONFIRMATION ☐ EMAIL CONFIRMATION ☐ TEXT MESSAGE TO MY CELL PHONE

☐ WORK PHONE CONFIRMATION ☐ HOME PHONE CONFIRMATION ☐ ANY OF THE ABOVE

I approve being contacted about special services, events, fund raising efforts or new health info on behalf of this Healthcare Facility via:

☐ PHONE MESSAGE ☐ TEXT MESSAGE ☐ EMAIL

☐ ANY OF THE ABOVE ☐ NONE OF THE ABOVE (OPT OUT)

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of 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 WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

________________________________ ________________________________

Please PRINT name of Patient **Please SIGN Patient/Guardian of Patient**

________________________________ ________________________________

Legal Representative/Guardian **Relationship of Legal Representative/Guardian**