

Marvin D. Bishop, D.M.D.

112 Lily Flagg Road S.E.

Suite B

Huntsville AL 35802

(256)881-4580

bishopdmd@gmail.com

www.marvindhunsvillal.com



Welcome to Marvin D. Bishop D.M.D.

Chart #.

FOR OFFICE USE ONLY

Patient Name:
Last First MI Preferred Name

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

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

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

Employer Name: Phone:

Address:

City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

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Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name:
Last First MI Preferred Name

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

Birth Date: SS #: Driver's License #:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

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Primary Dental Insurance:

Name of Insured:
Last First MI

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

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Insurance Company Phone Number:

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.

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Dental Information

How would you rate the condition of your mouth?

- Excellent Good Fair Poor

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

- 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- Had complications from past dental treatment
 Had trouble getting numb
 Had any reactions to local anesthetic
 Had/have braces, orthodontic treatment
 You experience dry mouth
 Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
 Food gets trapped between any teeth
 Have you ever whitened or bleached you teeth
 Have you experienced popping and/or clicking of your jaw joint

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- You have difficulty chewing
- You clench or grind your teeth
- You wear or have worn a bite appliance
- Gums bleed when brushing or flossing
- Treated for gum disease or were told you have lost bone around your teeth
- Noticed an unpleasant taste or odor in your mouth
- Experienced gum recession
- Had any teeth become loose on their own (without injury)
- Experienced a burning sensation in your mouth
- You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

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Consent for Services and Financial Policy

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 determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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 any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

* By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

HIPAA 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 revoked, 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 health care 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.

* By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

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Medical History

Patient Name:
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- | | | |
|---|--|--|
| <input type="checkbox"/> *PREMED | <input type="checkbox"/> Alcohol/Drug Use | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Allergy Codeine | <input type="checkbox"/> Allergy Penicillin | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Artificial Valve |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> No Epinephrine | <input type="checkbox"/> Osteoporosis Meds | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation/Chemo |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease |

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- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> Tobacco/Alcohol Use |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

- Excellent Good Fair Poor

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription) including regular doses of aspirin:

* By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Response Date: