FERGUSON & COATS General Dentistry

SECTION I: Date: ____________________________

Name: Dr. Mr. Mrs. Ms.____ Preferred Name: ____________________

Home Phone: ____ Cell Phone: ______________________________________

Home Address: ____ City/State/Zip: __________________________________

Email____ Preferred method of contact:___phone___email

Employer:____ Business Phone:__________________________________

Social Security #:____ Date of Birth: ____

Emergency Contact: _____________________________ Phone: _______________________ Relationship to Patient: ______________

Person Responsible for Account: ____ Relationship to Patient: ______________

Address (if different from above):____________________________________ City/State/Zip:________________________________

Social Security #: ____ Date of Birth: ____

Insurance Company: ____ Phone #: _____________________________________

Employer: ____ Business Phone: _________________________________

Group #: ____ Subscriber #: ___________________________________

SECTION II: How did you hear about us?

_____Website _____Social Media (Facebook, Instagram, Twitter) Other____

_____ Friend/Relative, whom may we thank? ____

_____ Other Dentist/Specialist, whom may we thank? ____

SECTION III: Reason for today's visit: ____

Date of last dental care: ____________________________________ Date of last dental x-rays: _________________________________

Please check if you have had problems with any of the following:

_____ Grinding or Clenching Teeth _____ Periodontal Treatment _____ Sensitivity when Biting _____ Bleeding Gums

_____ Loose Teeth or Broken Fillings _____ Sensitivity to Sweets _____ Sensitivity to Cold _____ Sensitivity to Hot

_____ Sores/Growths in Mouth _____ Clicking or Popping Jaw _____Food Collection b/t teeth _____ History of Fever Blisters

_____ Bad Breath Other: ____

SECTION IV:

1. Are you in good health? .... Y N
2. Are you currently under a physician's care? .... Y N

If so, what for?____

Treating Physician's Name: ____ Phone #: _____________________________

3. Have you had any serious illnesses, operations, or hospitalizations?.. Y N

If so, describe and give approximate dates: ____

____

4. Have you ever had intravenous sedation or general anesthesia? .... Y N

Were there any adverse effects? .... Y N

5. Do you generally tolerate dental treatment well? .... Y N
6. Have you ever been told by a dentist or physician that you needed to take antibiotics before dental procedures due to pre-existing health conditions? (ie: joint replacement surgery, congenital heart problems, etc.).. Y N
7. DO YOU HAVE OR HAVE EVER HAD:

A. Heart disease that was detected at birth? .... Y N

B. Rheumatic fever or Rheumatic heart disease? .... Y N

C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? .... Y N

D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? .... Y N

E. Neurologic disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)?.. Y N

F. Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)?....................................... Y N

G. Liver disease (jaundice, hepatitis)?.. Y N

H. Diabetes?.. Y N

I. Thyroid disease (hypothyroidism, tumor)?... Y N

<<< Please continue on other side of the form. >>>

SECTION IV CONT'D:

J. Arthritis? (which joints?) ______________________________ Y N

K. Stomach ulcers or Intestine problems? .... Y N

L. Frequent or recurring mouth sores?.............................. Y N

M. Implants/artificial joints anywhere in your body (heart valve, hip, knee)? .... Y N

N. Radiation (X-ray treatment for cancer) in head and neck region? .... Y N

O. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? .... Y N

P. Sinus or nasal problems? .... Y N

Q. Any disease, drug or transplant operation that has depressed the immune system?.............................. Y N

R. Recurrent infections of any kind? .... Y N

8. ARE YOU TAKING OR USING ANY OF THE FOLLOWING:

A. Antibiotics? .... Y N

B. Anticoagulants (blood thinners)? .... Y N

C. Thyroid medications? .... Y N

D. Antihistamines, decongestants?.............................. Y N

E. High blood pressure or heart medications?.............................. Y N

F. Steroids?.............................. Y N

G. Tranquilizers, antidepressants?.............................. Y N

H. Stomach or GI medications (antacids, etc.)? .... Y N

I. Cholesterol reducing drugs? .... Y N

J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers?.............................. Y N

K. Any of the bisphosphonate class of drugs (Boniva, Fosamax, etc.)? .... Y N

L. Marijuana, cocaine or other recreational drugs?.............................. Y N

M. Any other regular medications, pills, supplements or drugs?.............................. Y N

PLEASE LIST ALL CURRENT MEDICATIONS HERE: ______________________________

____

____

9. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

A. Local anesthetic (Novocain-like drugs)? .... Y N

B. Penicillin, Amoxicillin, Cephalosporins? .... Y N

C. Other antibiotics? .... Y N

D. Barbiturates, sedatives? .... Y N

E. Aspirin, ibuprofen, NSAIDS, or other pain relievers? .... Y N

F. Codeine or other narcotics or opioids? .... Y N

G. Latex? .... Y N

H. Other allergies or reactions? .... Y N

PLEASE LIST: ______________________________

____

10. Do you use alcohol? How much per day?______________________________ Y N

11. Do you smoke? If so, what product?_________________ How many per day?____________ For how long?__________________ Y N

12. Do you use spit tobacco? For how long?______________________________ Y N

13. Are you, or have you been, in a drug or alcohol recovery program?.............................. Y N

14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.............. Y N

15. Do you wish to talk to the doctor privately about anything?.............................. Y N

16. Any additional comments?______________________________

17. WOMEN

A. Are you taking birth control pills?.............................. Y N

B. Are you pregnant, trying to become pregnant, or any chance you might be pregnant? .... Y N

C. Are you BREAST FEEDING? .... Y N

D. Are you taking hormonal replacement?.............................. Y N

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance, as well as, any finance charges, collection, attorney, and court fees used to collect on my account. By signing below, I also acknowledge that I have received copies of the office policies regarding dental insurance and canceled/broken appointments. The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Ferguson, Dr. Coats or any member of their staff responsible for errors or omissions that I may have made in the completion of this form.

Signature: ______________________________ Date:______________________________

Office Policy Regarding Cancellations

& Broken Appointments

As a courtesy to our patients, and in an effort to provide the highest quality dental care as efficiently as possible, our office will confirm your appointment 24-48 hours prior to your appointment time. As a courtesy to our office and other patients, we require all patients give at least 24 hours notice if you will not be able to attend your scheduled appointment. Failure to provide our office with such notice will result in charges to your account. These charges will be determined depending on the type and length of appointment that was scheduled and are not covered by dental insurance. We reserve the right to discontinue treatment for patients who repeatedly break appointments.

____________________________________ ____________________

Signature Date

Ferguson and Coats, DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____
Address: ____
Telephone________________ Social Security Number: _________________________

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you will consent to our use of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy policy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Melanie Grable
Telephone: (662)323-2876 Fax: (662)338-0097
E-mail: office@fergusonandcoats.com
Address: P.O. Box 1407
Starkville, MS 39760

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent form will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to the following Personal Representative in order to carry out treatment, payment activities and health care operations.

Personal Representatives Name: ____

Relationship to Patient: ____

Signature: ____ Date:________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include a completed Consent in the patient's chart

405 Academy Road
P.O. Box 1407
Starkville, MS 39760
Phone: 662-338-9194 or 662-323-2876
Fax: 662-338-0097

DENTAL INSURANCE INFORMATION

Understanding your dental insurance benefits for your dental and after-care is very important. Every insurance policy is different in the way it pays for dental care. It is important that you **read and understand your particular policy**. If there are any questions concerning how your individual policy pays, we will be glad to help you. You will need to bring your benefits booklet, brochure, etc. so that we can make a copy of it. That way we can refer to it when questions arise.

Examinations, x-rays, and basic cleanings (prophylaxis) may be covered at 100% but not always. Some policies require a deductible to be met before paying for any procedure and many dental insurance companies pay a percentage or a set rate on dental procedures after you have met your deductible. It all depends on what plan your employer chooses to fund. We deal with 100 or more insurance policies and every one is different in their determination of benefits. We will do our best to estimate what your insurance will pay and then what you will owe for the co-payment at each appointment. If we have under-estimated the insurance payment, we will bill you for the difference.

Please understand that your insurance is based on the level of coverage chosen by you or your employer. The higher the premiums paid by you and/or your employer, the better the dental benefits are for you. This is strictly a money-based decision. Your insurance company's only interest is making a profit. You may see the term "UCR". This is just another term that means, "the fee charged for a procedure". Our fees are fair and standard for our area and are neither the highest nor the lowest in our area. But this does not mean the insurance payment will be based on 100% of our fees. Remember that the insurance payment is solely based on the premium paid in, not on what we charge!

Most dental procedures are covered by most insurance companies, but almost **never at 100%**. We have found that of the 100 or so insurance companies that we deal with, the average of insurance coverage is 50-80% on any given procedure. You can use this average to roughly estimate your co-payment. Purely cosmetic dentistry (bleaching, veneers, etc.) is seldom covered by any insurance company. Be aware that some policies do not cover, or cover at a very low rate, complex dental services. Unfortunately these types of policies (PPO, Capitation, DHMO, etc.) also pay poorly on even simple dental procedures.

We will always help you get the maximum benefits from any insurance coverage. However, Dr. Ferguson and Dr. Coats never base their diagnosis or treatment planning on what the insurance company will pay. DR. FERGUSON and DR. COATS RESPONSIBILITY IS TO YOU, NOT THE INSURANCE COMPANY. So please understand that though we realize the value of having dental insurance, insurance coverage (or lack of) does not dictate what your doctor recommends to his patients. Their judgment is based on criteria established during your examination.

By signing below, I acknowledge that I have read, reviewed, and fully understand both sides of this document. I have also received a copy of this document for my records and agree to comply as fully as possible with the cancellation/broken appointment policy of this office.

______________________________ ________________

Signature Date

FERGUSON AND COATS, DMD

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

SECTION A: The Patient

Name: ____
Address: ____
City: ______________________________ **State:** ________ **Zip:** __________________
Home Telephone: _________________________**Cell:** __________________________
Social Security Number: ____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature: _____________________________________ **Date:** ___________________

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ____
Relationship to Patient: ____

Office Manager: Melanie Grable
P.O. Box 1407, 405 Academy Rd. Starkville, MS 39760-1407
662-338-9194 / 662-323-2876 / Fax: 662-338-0097
office@fergusonandcoats.com