Derrick J. Dickerson, D.M.D., P.C.
6755 E. Superstition Springs Blvd., #203
Mesa, Arizona 85206
(480) 218-6030

Welcome To Our Office!

In order to serve you properly, we will need the following information (please print).
All information will be strictly confidential.

A.

(Marital Status: ____________________) Date: ____________________

Patient Name:

____
Last First Middle Initial "Nickname"

Address ____
(If P.O. Box, please give street address also)

City ____________________ State ____________ Zip ____________________

Home Phone ____________________ Work ____________________ Ext ________ Sex M ____ F ____

Cell ____________________ Pager ________________ Email ____________________

Date of Birth ____________ Social Security Number ____-____-____ Dr License # ____________

Employers Name & Address ____

Closest Relative, not living w/you: Name, Phone, & Address ____________________________

Other than Spouse, Alternate (emergency) Name ____________________ Phone ____________

Whom may we thank for referring you? ____

B.

Responsible Party Information (if different from above)

Name of Responsible Party ____________________ Dr. License # ____________________

Address ______________________________ Relationship to Patient ____________________

Home Phone ____________ Work Phone ____________ Ext ______ Birthdate ________ Sex M/F ______

Employers Name ______________________________ Social Security Number ____-____-____

C.

Payment or verification of insurance coverage is required at the time of treatment. For payment of fees or for paying your portion of fees not covered by insurance, we accept the following payment options. Please indicate your choice(s) of payment. We are happy to answer any questions you may have.

Cash ☐ Check ☐ Credit Card ☐ Finance Company ☐ Debit Card ☐

Do you have dental insurance? Yes ______ No ______

Name of Insurance Company ____

Address of Insurance Company ____

Name of Insured Person ____________ Soc Sec or I.D. # ____________ Date of Birth ____________

Address & Phone # ____

Employer/Group Plan of Insured ______________________________ Group # ____________

D.

What is the purpose of your visit today? ____

____

Are you having any pain or discomfort today? ____________________________________

How do you feel about visiting the dentist? ______________________________________

PLEASE COMPLETE NEXT PAGE ALSO

E.

DENTAL HISTORY

When was your last dental exam? ______________________ last cleaning? __________________

Is there anything you dislike about the appearance, color, and/or function of your teeth?

____

F.

MEDICAL HISTORY

Please circle any of the following which may apply to you now or in the past:

Heart Failure	Stroke	Shingles	Liver Disease	Drug Abuse
Heart Disease or Attack	High Blood Pressure	Hemophilia	Yellow Jaundice	Alcoholism
Artificial Heart Valve	Heart Pacemaker	Diabetes	Drug Addiction	Radiation Therapy
Artificial Joint/Implants	Congenital Heart Lesions	Thyroid Disease	Venereal Disease	Herpes/Cold Sore
Mitral Valve Prolapse	Angina Pectoris	Sinus Trouble	Glaucoma	Blood Transfusion
Heart Murmur	Pain in Jaw Joints	Heart Surgery	Epilepsy or Seizure	Emphysema
Rheumatic Fever	Hepatitis A (Infectious)	AIDS	Fainting or Dizzy Spells	Tuberculosis
Asthma	Hepatitis B (Serum)	HIV Positive	Bruise Easily	Allergies or Hives
Cancer or Tumors	Kidney Disease	Scarlet Fever	Chemotherapy	Taken Phen Fen

Any other diseases or health problems? ______________________________________

Do you smoke or use other forms of tobacco? ___________________________________

WOMEN: Are you pregnant? ____________________ If so, what is your due date? ______________

Are you allergic to metal jewelry, such as earrings?______________________________

Have you ever had an unusual reaction or an allergic reaction to an anesthetic or drug such as Penicillin, Erthromycin, Novacaine, Codeine, Aspirin, ETC? Yes ____________________________

____

Medications taking at present: ____

____

List any surgeries you have had in the past 5 years ______________________________

____

Who is your medical doctor ______________________ Phone Number ________________

G.

I understand that the above information is necessary to provide dental care in a safe efficient manner. I have answered all questions truthfully and to the best of my knowledge. I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to thoroughly diagnose dental needs. I also authorize the doctor to choose and employ assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services proved by this office for myself or my dependents is mine, **due and payable at the time services are rendered** unless other financial arrangements are made. In the event of default (we) promise to pay legal interest on the indebtedness, together with all collection costs and reasonable attorney fees as may be required to effect the collection of this note. **Fees not paid by the insurance company within 30 days, are due and payable from the patient or the responsible party.**

Signed Patient ______________________________ Date ____________________

Signed Parent or Responsible Party ____________________ Relationship to Patient ____________

H.

I hereby authorize my insurance benefits to be paid directly to doctor, Derrick J. Dickerson, D.M.D., P.C. I also authorize the Doctor to release any information required to process insurance claims.

Date ________________ Signature ______________________________
(Insured Person)

Date ________________ Signature ______________________________
(Patient, or parent/guardian of minor patient)

Date ____________________ Doctor's Signature ______________________________

Consent Form

We are committed to providing excellent care, great service, and a comfortable atmosphere and consider dental care a lifelong need. In order to serve you best, we will evaluate each tooth in your mouth, screen for oral cancer and review oral hygiene with you.

As a condition of your treatment in this office, financial arrangements ***must be made in advance***. The practice depends upon reimbursement from the patient for the costs incurred in their care and treatment. The financial responsibility on the part of each patient must be determined prior to start of treatment. ***The portion of the estimated cost for the patient is due at the time of the scheduled procedures.***

I realize and agree insurance coverage is ***estimated*** and not a guarantee of the actual insurance payment, my actual coverage may be more or less than estimated. I, the patient, realize and agree that my insurance will help pay part of my treatment and that any estimates quoted to me ***are only estimates***. I, the patient, will ultimately be responsible for any portions remaining unpaid by insurance carrier. I understand and agree to pay any unpaid balance **within *thirty (30) days* of date of invoice**. I understand and agree that I will be charged a late fee of $10.00 per month of any unpaid balance on my account. I understand and agree that I will be responsible for any collection, attorney and/or court fees associated with my account.

I understand and agree the fee estimate is valid for *sixty (60) days* from the original date of the patient's examination. Thereafter, fees are subject to change without notice.

I understand and agree that I am required to allow ***at minimum*** a *twenty-four (24)* hour notice to Dr. Dickerson and/or staff should I need to reschedule or cancel my exclusively reserved appointment time. I understand and agree that I will be charged a fee of $75.00 for any missed appointments.

I give my consent to use local anesthetics, relaxants, analgesia (laughing gas), antibiotics, or pain medication if deemed necessary for the completion of any dental treatment. Women taking birth control, pills should be aware, that antibiotics such as penicillin or erythromycin could possibly counteract the affects of the pill and you could become pregnant.

I understand and agree that whenever a tooth is extracted, there is a ***possibility*** of infection, bone fracture, temporary paresthesia (*numbness*) of the lip, gum, tongue and/or facial skin. It is possible though *rare*, that the paresthesia would be permanent.

I understand and agree that a root canal is *an attempt to retain a tooth that would otherwise require extraction*. Although root canal treatment has a high degree of success, ***it cannot be guaranteed***. As the root is being treated the root may fracture, instruments may separate, and portions of the canal may be inaccessible to instruments or sterility. It may require a referral for re-treatment, surgery, or (***rarely***) extraction.

I realize a specialist can perform any of the work the doctor proposes. *I will inform the doctor if I desire a specialist to perform the work.*

I understand and agree that the preparation of teeth for crowns, bridges, and fillings may, on occasion, traumatize the pulp (nerve). *If the pulp (nerve) is in a weakened condition, this may necessitate a root canal or extraction on that tooth in the future.*

I ***grant my permission to Dr. Dickerson and his staff*** to contact me in writing or by telephone at home, work, or cellular to discuss any matters related to my account, appointments, and/or this form.

I have read the above conditions of treatment and payment and agree to their content.

SIGNED ______________________________ DATE ______________