

Madison Family Dentistry

927 Highway 51

Madison, MS 39110

Lance D. Dillon D.M.D.

<i>Health Information</i>	<i>Payment Policy</i>																																										
<p>Date of Last Dental Visit:</p> <p><u>Do</u> you have any of the following?</p> <p>Please Check those that apply.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> AIDS</td> <td><input type="checkbox"/> Hay Fever</td> <td><input type="checkbox"/> Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/> Allergies</td> <td><input type="checkbox"/> Head Injuries</td> <td><input type="checkbox"/> Sinus Problems</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Heart murmur</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Artificial Joints</td> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Tumors</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Ulcers</td> </tr> <tr> <td><input type="checkbox"/> Blood Disease</td> <td><input type="checkbox"/> Jaundice</td> <td><input type="checkbox"/> Venereal Disease</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Kidney Disease</td> <td><input type="checkbox"/> Codeine Allergy</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Liver Disease</td> <td><input type="checkbox"/> Penicillin Allergy</td> </tr> <tr> <td><input type="checkbox"/> Dizziness</td> <td><input type="checkbox"/> Mental Disorders</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> Nervous Disorders</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Excessive Bleeding</td> <td><input type="checkbox"/> Pacemaker</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Fainting</td> <td><input type="checkbox"/> Pregnancy</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Radiation Treatment</td> <td><input type="checkbox"/></td> </tr> </table> <p>Please list all medication being taken.</p> <hr/> <p>Have you ever had any complications following a dental treatment?</p> <hr/> <p>Have you been admitted to a hospital or needed emergency care during the past two years?</p> <hr/> <p>Name and Phone Number of Physician?</p> <hr/> <p>Contact in case of an emergency.</p> <p>Name _____ Ph. _____</p>	<input type="checkbox"/> AIDS	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Allergies	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tumors	<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Codeine Allergy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Other:	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Pacemaker	<input type="checkbox"/>	<input type="checkbox"/> Fainting	<input type="checkbox"/> Pregnancy	<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/>	<p>Payment is due at the time services are rendered unless prior arrangements have been made with our office. We accept cash, check, MasterCard, Visa, American Express and CareCredit. CareCredit is an outside source of revolving credit, which can be applied for at our office.</p> <p>We file most insurance companies and do so as a courtesy to our patients. Our fees are considered to fall within the acceptable range of most insurance companies and therefore maybe covered up to the maximum allowance determined by each carrier. Please authorize insurance benefits to be paid directly to Madison Family Dentistry and understand that you are responsible for the payment of deductibles, co-payments, and any balances not covered by insurance. Also understand that you are responsible for any and all collection of this account.</p> <p>By signing, you authorize Madison Family Denstistry to release any information required to process all claims.</p> <p>We will try to obtain payment for the dental visits for a resasonable amount of time; however, if the insurance company refrains from timely payment, it will be the responsibility of the patient to pay for the services rendered and follow up with the insurance company.</p> <p>We look forward to a relaxed and pleasant visit with you. Should you ever have any questions or concerns, please call anytime.</p> <p>Signature _____ Date _____</p>
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FOR OFFICE USE ONLY (patient notes)																																											

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The ADA recommends fluoride for children and certain diagnostic x-rays approximately every 6 months. However, most insurance companies differ in their coverage. We recommend that you understand your coverage information and inform our office if you want to alter treatment due to insurance.

We do not set our treatment goals for your family to satisfy insurance carriers. We set our goals to offer our patients comprehensive care. Each person should evaluate their benefits and be aware of covered and non-covered procedures. We can not be responsible for detailed knowledge of each and every dental plan. Please be aware of any changes in your insurance. We will always obtain a general benefit coverage table and will always file your insurance. Thank you for your cooperation.

× _____
Signature