Justin L. Morrison, DDS

GENERAL FAMILY DENTISTRY

Today's Date: ________________

Mr/Miss/Mrs/Dr Patient's name ___________________________________ Preferred name __________________

Birth date__________ Gender: ❑Male ❑Female Social Security number:___________________

Marital Status: ❑ Minor ❑Single ❑Married ❑Divorced ❑ Widowed ❑ Seperated

If minor, parents/guardian names:__________________________

Home phone ____________________ Work phone____________________ Cell phone____________________

Email:____

Mailing address ___________________________ City ____________________State ________ Zip ___________

Employer _____________________________________ Occupation _______________________________________

Employer Address: ____

Whom may we thank for referring you to our office?

____

Family Physician: ___________________________ Address: ____

Dental Insurance Carrier: _____________________________ Group Number: _______________________

Do Any of the Following Chief Complaints Apply to You:

- ❑ Currently in Pain
- ❑ Diet limited to semisolid or soft foods
- ❑ Diet limited to liquid foods
- ❑ Difficulty chewing and speaking
- ❑ Digestive problems
- ❑ Do you feel that your oral condition is affecting your general health in any way?
  ____
- ❑ Facial pain
- ❑ Gags easily
- ❑ Head pain/Headaches
- ❑ Jaw clicks/pops
- ❑ Limited opening of jaw
- ❑ Loss of teeth
- ❑ Lower jaw locks open
- ❑ Mouth sores
- ❑ Numbness in lower lip
- ❑ Numbness in jawbone
- ❑ Nutritional disorders
- ❑ Pain in jawbone
- ❑ Pain in jaw joint
- ❑ Pain when swallowing
- ❑ Teeth do not meet properly
- ❑ Tingling in jawbone
- ❑ Other_________________________
- ❑ None

List Any Medications/Substances Which Have Caused an Allergic Reaction:

- ❑ Antibiotics
- ❑ Aspirin
- ❑ Barbituates
- ❑ Codeine
- ❑ Hydrocodone
- ❑ Lidocaine
- ❑ Latex
- ❑ Metals
- ❑ Plastic
- ❑ Sedative
- ❑ Sleeping Pill
- ❑ Local Anesthetics
- ❑ Other: ________________________
- ❑ Please note specific drug/medication that caused allergy:
  ____
  ____
- ❑ Not Applicable

Justin L. Morrison, DDS

GENERAL FAMILY DENTISTRY

List Any Medications You Are Currently Taking:

- ❑ Antibiotics
- ❑ Insulin
- ❑ Anticoagulants
- ❑ Muscle Relaxants
- ❑ Barbituates
- ❑ Blood Thinners
- ❑ Pain Medication
- ❑ Codeine
- ❑ Sleeping Pills
- ❑ Cortisone
- ❑ Sulfa Drugs
- ❑ Ginko Biloba
- ❑ Diet Pills
- ❑ Heart Medication
- ❑ Tranquilizers
- ❑ Medications for Osteoporosis
- ❑ Bisphosphonates (Fen Phen, Fosamax, Boniva, etc)
- ❑ Herbal Supplements
- ❑ Other: ________________________________
- ❑ None

Medications and Dosages:
____
____
____

Have you ever been told you need a Pre-Medication prior to your dental appointment? Yes or No

Please list other healthcare practitioners seen within the last year:

Practitioner	Specialty	Treatment and Approx Date

Any surgeries in the last 2 years: Yes or No. If yes, please list below:
____
____
____

Do you take aspirin regularly: Yes or No

Do you smoke or chew tobacco: Yes or No. If yes, how much on a daily basis: ______________________________

Medical History:

- ❑ Abnormal bleeding after surgery/injury
- ❑ AIDS
- ❑ Anemia
- ❑ Allergic Rhinitis
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Autoimmune disorders
- ❑ Bleeds easily
- ❑ Bloating
- ❑ Bruising easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chronic Bronchitis
- ❑ Chronic Fatigue
- ❑ Chronic Drymouth
- ❑ Cold Hands and Feet
- ❑ Colitis
- ❑ Current Pregnancy
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive Thirst
- ❑ Extra Pillows to help breathing at night
- ❑ Fainting Spells
- ❑ Fluid Retention
- ❑ Frequent Cough
- ❑ Frequent Illnesses
- ❑ Frequent Stressful Situations
- ❑ Glaucoma
- ❑ Gout
- ❑ Hay Fever
- ❑ Headaches
- ❑ Hearing Impairment
- ❑ Heart Disorders

Justin L. Morrison, DDS

GENERAL FAMILY DENTISTRY

- ❑ Heart Murmur
- ❑ Heart Pacemaker
- ❑ Heart Valve Replacement
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Hypoglycemia
- ❑ Immune System disorder
- ❑ Injury to: Face, Neck, Mouth, Teeth
- ❑ Insomnia
- ❑ Intestinal disorders
- ❑ Jaw Joint Surgery
- ❑ Kidney Problems
- ❑ Liver disease
- ❑ Other Medical/Dental History:________________________________ ______________________________________
- ❑ Low Blood Pressure
- ❑ Multiple sclerosis
- ❑ Muscle aches
- ❑ Muscle shaking (tremors)
- ❑ Muscle spasms or cramps
- ❑ Muscle dystrophy
- ❑ Nervousness
- ❑ Neuralgia
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Parkinson's disease
- ❑ Poor circulation
- ❑ Prior orthodontic treatment
- ❑ Psychiatric treatment
- ❑ Rheumatoid arthritis
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Shortness of breath
- ❑ Slow healing sores
- ❑ Sickle Cell Anemia
- ❑ Sinus problems
- ❑ Speech difficulties
- ❑ Stomach Problems
- ❑ Stomach ulcers
- ❑ Stroke
- ❑ Swelling of ankles
- ❑ Tendency for frequent colds
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Urinary Disorders
- ❑ None of the above are applicable

Women: Are you currently pregnant or trying to get pregnant? Yes or No

Patient Signature X____

Our Office Financial & No Show Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND DISCOVER CREDIT CARDS, AND DEBIT CARDS.
WE ALSO OFFER **CARE CREDIT & Lending Club** WHICH ARE EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL.

Regarding Insurance
We cannot bill your insurance unless you call or bring in all insurance information prior to your dental visit. If we have all of your insurance information prior to your appointment, we will be happy to file your dental claim as a courtesy to you. We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided.

PLEASE UNDERSTAND that we file your dental claim as a courtesy to our patients. Your insurance policy is a contract between you and your insurance company. We are not responsible for how your insurance handles its claims or for what benefits they pay on a claim. We can only assist you in ESTIMATING your portion of the cost of treatment, we at no time guarantee what your insurance will or will not do with each claim. Please be aware some and possibly all of the services provided may not be covered services and not considered reasonable, usual, and customary under the terms of your dental policy.

You are responsible for any balance on your account after 60 days, whether your insurance company has paid or not. We will be glad to send a refund if your insurance company does end up paying. If there is an outstanding balance on the account for more than 60 days, you and other family members will not be able to receive treatment until balance is paid in full.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients
Adult patients are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to point this out when we call to confirm your appointment.

Minor Patients
The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified. Consent for treatment will also need to be pre-approved or verbal consent in case of an emergency.

Payment Plans

Justin L. Morrison DDS has partnered with Care Credit & Lending Club, patient financing companies, to offer our patients 0% interest financing for 6 or 12 months with approval. No other payment plans are available.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a $25 per hour of the appointment. Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. After 2 missed appointments you will be required to make payment in full to reschedule the appointment, or you will not be allowed to reschedule.

Excessive cancellations and no shows will result in termination of our doctor/patient agreement and your records can be forwarded to another dental office.

Pre-Payment

There are procedures that require a pre-payment deposit of at least $50 for treatment; this is to be paid in advance prior to scheduling. If the patient no shows the appointment or cancels with less than 24 hour notice the pre-payment will be non-refundable, and another $50 pre-payment deposit is required to reschedule.

Billing

If there is a balance on the account after insurance has paid we will send a statement in the mail- payment is due upon receipt. There is a $30 returned check fee.

Refunds

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected on all of your family members.

Collections

Any account that has not received a minimum payment of at least 20% of the balance within 90 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

Printed Name: ________________________________

Signature: ____________________________________

Justin L. Morrison, DDS

GENERAL FAMILY DENTISTRY

Medical Information Release Form

(HIPAA Release Form)

Name: ___________________________________ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren)______________________________________

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (*day*)___________________ between (*time*)_________

Signed: ______________________________________ Date: ____/____/_____

Witness:______________________________________ Date: ___/____/______

Medicare Opt Out Form:
This contract is between Justin L. Morrison, DDS ("Dentist") and Patient or Patient's legal representative listed below (Medicare beneficiary, referred to in this contract as "Patient"). Justin L. Morrison, DDS has elected to opt out of Medicare. A dentist who opts out is not required to submit claims on behalf of beneficiaries and is not subject to Medicare limits on charges for covered services.
1. Justin L. Morrison, DDS represents that he "is" excluded from participation under the Medicare program under 1128, 1156 or 1892 of the Social Security Act.
2. Patient (or Patient's legal representative) and Justin L . Morrison, DDS agree that Patient is not now facing an emergency or urgent health care situation.
3. By signing this contract, Patient (or Patient's legal representative) does the following:
a) Accepts full responsibility for payment of Dentist's charge for all services furnished by Dentist;
b) Understands that Medicare limits do not apply to what that Dentist may charge for items or services furnished by the Dentist;
c) Agrees not to submit a claim to Medicare or to ask Dentist to submit a claim to Medicare;
d) Understands that Medicare payment will not be made for any items or services furnished by Dentist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;
e) Enters into this contract with the knowledge that Patient has the right to obtain Medicare-covered items and services from dentist, physicians, and practitioners who have not opted out of Medicare, and that Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other dentists, physicians, or practitioners who have not opted out;
f) Understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;
4. This form will have to be signed every 2 years by the patient, as required by Medicare.

This contract shall remain in force and effect from the date it is signed by the Patient until the end of the term of the Dentist's current opt-out period.

Patient Name: ________________________________ Date: __________________

Patient Signature: ______________________________