John A. Maddox D.M.D., L.L.C.

Family and Cosmetic Dentistry

Welcome to the office of Dr. John A. Maddox. It is the intention of our team to provide you with comprehensive and affordable dental care.

Payments
Our team strives to make every effort to advise you of your estimated financial responsibility prior to patient care. If at any time you have any questions about treatment or financial estimates please notify a team member promptly, as we value an open and honest financial relationship with all of our patients. Our office accepts the following payment types:

Cash/Check
American Express
Visa/Master Card
Discover Card
Care Credit Patient Financing

There will be a non-refundable **service fee of 4%** assessed for the use of all Debit/Credit card transactions.

All co-payments and deductibles are due at the time services are performed.
Insurance
Our office files for dental benefits on all dental plans. However, Dr. Maddox is not a contracted provider. Our office will be happy to file and manage any out of network insurance plans but all co-payments and deductibles are due at time of service. If the dental plan sends benefit payments directly to the subscriber, payment from the patient will be collected in full at the time of service.

Our office team provides you with the service of filing, tracking and auditing your insurance benefits. However, we do recognize that your dental insurance is an agreement between you and your employer and you are ultimately responsible for all dental fees relating to your care. Please note that regardless of dental insurance coverage, our office relies on you for settling your account in full and may request that you assist us if the claim filed on your behalf has issues.

Emergency and Non-Insured Patients
All patients with no insurance and for ALL emergency patients, payment is due in full at the time services are performed.

NSF Fees
Our office charges a $75.00 insufficient funds fee (NSF) for any returned check. We reserve the right to no longer accept checks as a form of payment from any account that has a NSF return.

Treatment Estimates
Our staff strives to give the closest estimate of treatment financial responsibility based on what information the insurance company provides to us. However, we can file a **Pretreatment** claim to your carrier to get a more exact figure. This process usually takes 2-4 weeks. Please feel free to request this service.

Cancellation Policy
We strive to render excellent dental care to you, your family and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is late cancelled or missed, that time cannot to be used to treat another patient.
We ask that you give our office 24 hours' notice from the time of your appointment in the event that you need to reschedule or cancel your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment and a fee of $75.00 will be charged to you upon your late cancellation or not showing for your scheduled appointment; if you have insurance, your policy will not cover this expense and will be your direct responsibility. Additionally, if a patient is more than 15 minutes late, without prior notice for a scheduled appointment, we will consider this a missed appointment and the $75.00 cancellation fee will be charged and must be paid prior to rescheduling the missed appointment.

Agreement
If you have any questions regarding this policy, please let our team know and we will be glad to clarify any questions you have. We thank you for your patronage.
I have read and understand the office policies for Payments and Appointment Cancellation of the practice and I agree to the terms. I also understand and agree that such terms may be amended from time to time by the practice.

General Consent for Treatment

I, the undersigned, understand and authorize the doctor to take radiographs (x-rays), study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I assume the right and responsibility to ask for any risks of treatment, alternative treatments, as well as the financial responsibility of the treatments.

I understand that the use of local anesthetics embody a certain risk. Complications and side effects are rare, but may include, among others not listed: Swelling, bruising or soreness at the injection site, numbness outside of the mouth, temporary rapid heartbeat, damages to the nerves resulting in temporary or possibly permanent numbness or tingling of lips, chin, tongue or other areas, severe allergic and possible life threatening reactions necessitating emergency care. I understand that if I have high blood pressure, uncontrolled thyroid problems, angina or have recently had a heart attack that I will inform my dentist verbally without fail as these conditions have caused complications for persons receiving local anesthesia. I assume the right and responsibility to ask for any alternative treatments, as well as the financial responsibility of the treatments.

I confirm that I am over the age of 18 years old (If not please stop and notify the front desk). I understand that I am responsible for payment for the services provided for myself, or my dependents and it is payable at the time of services rendered or by the Financial Policies guidelines that I have read and understand. I authorize payment to be issued by my insurance carrier directly to this office. I also understand that any balance from the insurance company that is not resolved after 45 days is my responsibility. In the event an account is turned over to an attorney, I agree to pay all reasonable attorney fees, court cost and other cost associated with the collection of the account.

Disclosure of Health Information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information by US mail or email.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.
- We may need to use your personal information such as address, phone or email to remind you of your appointments, send treatment plans and other correspondence necessary for your dental and financial needs.

We strive to keep all patient information secure but unfortunately there is no assurance of confidentiality of information when communicating this way.

Acknowledgment

I have read, had all my questions answered and understand/agree to the above communication methods, office financial policies and procedures and also to the general consent for treatment.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Policies/Consent.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00