PAYMENT POLICY

Dr. Brackett *DOES NOT* participate with any insurance plan. **Charges** for initial visit, whether examination or emergency, **are payable in full at the time services are rendered.** As courtesy, we will file an insurance claim for reimbursement directly to you or provide you with paperwork to file. We will accept payment directly from your insurance company when applicable. However, YOU are responsible for any balance not covered by your insurance plan. Please consult with our business assistant concerning a need for partial payment prior to treatment. Fees not paid within sixty (60) days are subject to a past-due billing charge of $2.00 or 1.5% per month, whichever is greater. All costs of collection by attorney/collection companies will be your responsibility as well.

RELEASE

I authorize Dr. Brackett to perform diagnostic procedures and treatment as may be necessary for proper dental care. I hereby authorize payment of insurance benefits directly to Dr. Brackett otherwise payable to me. I authorize release of any information concerning my (or my child's) health care, advice and treatment to my insurance company relating to any claims on my (or my child's) behalf. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. **I understand that I am financially responsible for payment in full of all accounts.** By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid I whole or in part by my dental care payor.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Website.

AUTHORIZATION FOR DENTAL INSURANCE

I certify that I, and/or my dependent(s), have insurance coverage with **<<prim_insurance_company>>** and assign directly to Dr. Brackett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Doctor Brackett may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determine insurance benefits or the benefits payable for related services.

ACKNOWLEDGEMENT OF RECIEPT

I acknowledge that I received or read a copy of Dr. John H. Brackett's Notice of Privacy Practices.

Patient Name ____

Signature ______________________________ Date ________________

HISTORY MEDICAL for: Name: ________________________ Birth Date:________________

Your mouth is the first stage of your digestive system. Improper care at this stage can dramatically affect your heart as well. All medical history and medications being taken are critical information to help us treat and maintain your dental health.

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 Please List Medications: ______________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No ______________________________

____

Do you take, or have you taken, Phen-Fen or Redux? ☐ 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? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Milk

☐ Other If yes, please explain:______________________________

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatism
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Shingles
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Sickle Cell Disease
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sinus Trouble
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Spinal Bifida
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stroke
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Swelling of Limbs
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Tonsillitis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tuberculosis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tumors or Growths
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Ulcers
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Venereal Disease
			☐ Rheumatic Fever	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: ______________________

____

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

Today's Date:	

First Name:	Last Name:	Preferred Name:

Address:	City, State, Zip:

Date of Birth:	Sex:	Social Security Number: (only if needed for insurance)	☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐ Partnered for _____years

Home Phone:	Cell Phone:	Would you like to receive text message alerts for appointments? ☐ Yes ☐ No	Occupation:

Work Phone:	E-mail:	Would you like to receive correspondences via e-mail? ☐ Yes ☐ No

Whom may we thank for referring you?	Have you visited our Website? ☐ Yes ☐ No **www.DOCOFTHEBAY.com**

Preferred Pharmacy:	In case of emergency who should be notified? ________________________ Phone (____) _____-__________	Can we contact this person if you are not available? ☐ Yes ☐ No

Responsible Party If other than Patient	Responsible Party other then Patient:	Relationship to responsible party: ☐ Spouse ☐ Daughter ☐ Son ☐ Other _______________
	Address if other than Patient's:	Does Responsible party have custodial duties to the Patient? ☐ Yes ☐ No
	Responsible Party's Phone Number:	Please explain if the answer is NO:

Dental Benefit Information (Not Medical)			
	Policy Holder:	Relationship to Primary Policy Holder:	Policy Holder's DOB:
	Address if different from above:		
	Employer:	Employer Address:	
	Insurance Company:	Policy Number:	Group Number:
	Name of other dependents covered under this plan:		

Reason for Today's Visit ____________________________Date of last dental care _________

Former Dentist ____________________________________Date of last dental x-rays ________

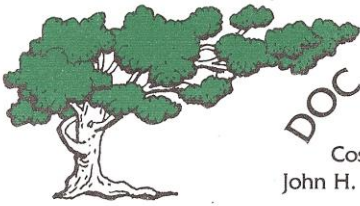
Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Sores or growths in your mouth

Sensitivity to (please circle) COLD / HOT / SWEETS / BITING

How often do you floss? ______________ How often do you brush? _____________________

Have you ever been diagnosed or treated for Periodontal (gum) disease? ___________________



25771 Canal Road • Orange Beach, AL 36561 Phone (251) 981-2273 (CARE)

RELEASE OF X-RAYS

I, ____________________________ hereby authorize the release/transfer of current x-rays, progress notes, and applicable medical records to:

(Please indicate doctor)

Please email digital x-rays if able.

John H. Brackett, DMD
25771 Canal Road
Orange Beach, AL 36561
(251) 981-2273 FAX (251) 981-2132
info@docofthebay.com

To/FROM:

Dr. ____________________________________

Address: ________________________________

City, St, Zip: _____________________________

Phone: _________________________________

Email: __________________________________

__________________________ __________________________
(Print Name) (Signature)

Date of Patient's Birth: _________________________