Welcome To Our Practice!

PATIENT INFORMATION

Last Name First Name MI	Name you prefer	Birthdate	Age	Home Phone ( )

Mailing Address	City	State	Zip	Work Phone	Other(Cell)

Employer (or school)	Business Address	City	State	Zip

Social Security Number	Marital Status (Circle one) Single Married Child Other	Male Female

Who may we thank for referring you to our office?	Is another member of your family a patient at our office? Name Relationship
	E-Mail Address

PERSON RESPONSIBLE FOR ACCOUNT

Name	Relationship to Patient

DENTAL INSURANCE INFORMATION

PRIMARY	SECONDARY
Ins. Company	**Ins. Company**
Employer Name	**Employer Name**
Employee Name	**Employee Name**
Social Security No.	**Social Security No.**
Contract No.	**Contract No.**
Group No.	**Group No.**

FAMILY INFORMATION

FATHER/HUSBAND			MOTHER/WIFE		
Name			Name		
Street Address			**Street Address**		
City	**State**	**Zip**	**City**	State	Zip
Home Phone	**Work Phone**		**Home Phone**	Work Phone	
Birthdate	**Social Security Number**		**Birthdate**	Social Security Number	
Employer Name			Employer Name		
Nearest relative NOT living with you (in case of emergency)			Telephone		

Address	City	State	Zip

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the Group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X_____ DATE_____

PLEASE CIRCLE ONE

Adult Patient Father (Husband) Mother (Wife) Guardian

PLEASE TURN TO 2ND PAGE & SIGN AT THE BOTTOM OF BOTH PAGES

Revised 11/10

Dental History

Y	N	Don't Know		Y	N	Don't Know	
☐	☐	☐	Do your gums bleed when you brush and floss?	☐	☐	☐	Have you ever had orthodontics (braces)?
☐	☐	☐	Are your teeth sensitive to cold, hot, pressure or sweets?	☐	☐	☐	Do you have headaches/earaches/jaw/neck pain?
☐	☐	☐	Have you ever had periodontal (gum) treatment?	☐	☐	☐	Do you wear removable dental appliances?

Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain:_____

_____ _____

How would you describe your current dental problem, if any? _____

Date of your last dental exam _____Date of last dental x rays _____

What was done at that time? _____

How do you feel about the appearance of your teeth?_____

Medical History

Y	N	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any major change in your health in last year?
☐	☐	☐	Are you now under the care of a physician? If so, condition being treated _____

Physician _____

Name Address Phone

☐ ☐ ☐ Are you taking any medications, including non-prescription medicine? If so, please list:

Prescribed: _____

Over the Counter: _____

☐ ☐ ☐ Do you drink alcoholic beverages?

☐ ☐ ☐ Do you smoke or use tobacco products?

☐ ☐ ☐ Are you pregnant? If yes what month?_____ Are you taking birth control pills? YES NO

Please CIRCLE if you have had any of the following:

Liver Disease	Seasonal Allergies	G. E. Reflux	Congestive Heart Failure*
Hepatitis A (infec.)	High or Low Blood Pressure	Neurological Disorder	Angina
Hepatitis B (serum)	Diabetes	Blood Disease or Anemia	Arteriosclerosis
Alzheimer's Disease	Hypoglycemia	Epilepsy or Seizures	**Artificial Heart Valve**
Latex Allergy	Radiation or Chemotherapy	Cancer / Tumor	Heart Attack or Stroke
Hemophilia	Thyroid Disease	Osteoporosis	Heart Murmur*
Sexually Transmitted Dis.	Developmentally Disabled	Migraines	**Mitral Valve Prolapse***
Emphysema	A.I.D.S/ HIV Inf.	Fainting or Dizziness	Pacemaker
Liver Disease	Eating Disorder	**Artificial Joints/Hips***	Rheumatic Heart Disease*
Arthritis / Rheumatoid	Asthma	Blood Transfusion year ____	**DRUG ALLERGIES:**
Kidney Trouble	Tuberculosis	Other _____	_____
			_____

* Recent Surgery - What type or kind _____ What Year _____

Have you ever had any other serious illness not circled above?_____YES NO

Please describe in detail_____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patients dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all services are due to be paid in full at time service is rendered. I also understand any unpaid balances from my insurance company are due to be paid in full within 60 days from date of service, whether or not my benefit reimbursement has been received. I also acknowledge that 18% APR (1.5% monthly) will be charged to my account for unpaid balances. I accept the fees charged as a lawful debt and promise to pay said fee including the cost of collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Mississippi, or any other state.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

X Patient Signature (Parent or Guardian)_____ X

Date_____ Reviewed by:_____ Date_____ Reviewed by:_____ Date:_____ Reviewed By:_____

Date_____ Reviewed by:_____ Date_____ Reviewed by:_____ Date:_____ Reviewed By:_____

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