



**HATTIESBURG**  
**FAMILY DENTAL CARE**

6142 U.S. Highway 98, Suite 10  
Hattiesburg, MS 39402  
Phone: (601) 450-1123  
Fax: (601) 450-1127



## Patient Information

Date \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial

I prefer to be called: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employer \_\_\_\_\_ Employer Phone (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_



## Primary Insurance

Person Responsible for Account \_\_\_\_\_ Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone (\_\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_



## Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand if I am unable to keep my appointments, I must kindly give 24 hours notice, or I will be charged a cancellation fee.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**



# Dental History

Reason for today's visit

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# Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Date of Last Dental Cleaning \_\_\_\_\_ XRays \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had any of the following:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Addiction                    | <input type="checkbox"/> Cough, Persistent        | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Cough up Blood           | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stomach Problems           |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Arthritis, Rheumatism        | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Mental Disorder       | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Artificial Heart Valves      | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Artificial Joints Year? ____ | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Back Problems                | <input type="checkbox"/> Headaches/Injuries       | <input type="checkbox"/> Pregnancy             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Blood Disease                | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tumors                     |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Heart Problems/Surgeries | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemical Dependency          | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy                 | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Scarlet Fever         | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Circulatory Problems         | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Sinus Problems        |   |
| <input type="checkbox"/> Cortisone Treatments         | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Shortness of Breath   |   |

### MEDICATIONS

List medications you are currently taking:

Pre-medication required?  Yes  No

If yes, why? \_\_\_\_\_

Do you take:

Bisphosphonates? (Example: Boniva, Fosamax, Zometa, Actonel, etc.)

Blood thinners? (Example: Eliquis, Plavix, Coumadin, Xarelto, etc.)

Other? \_\_\_\_\_

### ALLERGIES

- Penicillin
- Codeine
- Aspirin
- Latex
- Other \_\_\_\_\_



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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**Section A: Patient Giving Consent**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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**Section B: To the Patient -- Please read the following statements carefully**

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, paying activities, and healthcare operations.

Notice of privacy practices: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. You may obtain a copy of our Notice of Privacy Practices by contacting Lana J. Clarke, DMD or Suzannah Shook, DMD

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice submitted. Please understand that revocation of this consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

**Signature**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, \_\_\_\_\_, have received  
a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
Date

For Office Use Only
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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)



## Financial Policy

- Payment is due when services are rendered unless prior arrangements have been made.
- We offer payment plans through Care Credit upon approval.
- As a **courtesy** we will file your insurance for you.
- A cancellation fee of \$25.00 will be charged if you fail to contact us within 24 hours of your appointment time. This time is set aside for you. Please be courteous and contact us if you are unable to make your appointment.
- If your account is sent to a collection agency you will be charged their collecting fee, which is 35% of balance.
- By signing this form you agree to terms and conditions.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**In order for our office to better notify you and your family regarding your upcoming dental appointments, please indicate how you would prefer to be notified.**

**Via Text (mobile #):** \_\_\_\_\_

**Via Email:** \_\_\_\_\_ @ \_\_\_\_\_

**Via Phone Call:** \_\_\_\_\_

**\*Please notify us regarding new numbers and/or addresses as soon as possible so our office can update your information\***

**Signature:** \_\_\_\_\_