



For your convenience you may use your keyboard and mouse to complete this form. Our goal is to help you achieve and maintain excellent dental health. The better we communicate, the better we can care for your needs. If you have any questions, we'll be glad to help! Please print the form and fax, mail or bring it with you to your next appointment. Our fax numbers are Brandon: 601-825-7507 and Flowood 601-936-0125 and our mailing addresses are:
Brandon Office: 1350 W. Government St., Brandon, MS 39043, 601-825-3807
Flowood Office: 4802 Lakeland Dr., Flowood, MS 39232, 601-936-0025

Our Commitment to You

We would like to take this opportunity to welcome you to our dental practice. We are pleased that you have chosen us as your dental care team and want you to know that we are committed to providing you with the highest quality dental care in the most gentle, efficient and enthusiastic manner possible! We appreciate your understanding in our efforts to maintain respectful guidelines for our practice to keep the caliber of care and service extraordinary.

Treatment

Our goal is to build a long-term relationship with you in a relaxed and friendly environment. We are committed to helping you preserve your natural teeth for life and to maintain your oral health at an optimum level. We want to assure you we will be with you every step of the way and welcome any questions you may have.

By initialing this section and signing below, you indicate that you understand and agree to these treatment guidelines.

Initial _____

Financial Arrangements

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are available to answer your questions and assist you in any way we can. We happily accept cash, checks, credit cards (VISA, MC, and Discover) and long term outside financing through Care Credit (o.a.c.). All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion co-pays at the time treatment is provided.

By initialing this section and signing below, you indicate that you understand and agree to these financial guidelines.

Initial _____

Insurance

We are pleased that you have dental insurance to help you with partial assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

" Insurance is an agreement between you and your insurance company. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy.

By initialing this section and signing below, you indicate that you understand and agree to these insurance guidelines.

Initial _____

Appointments

We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute changes, other patients in need of treatment cannot be seen and your treatment is delayed, often resulting in negative consequences.

Should any scheduling changes be required, we require at least 48 hours advance notice to avoid a \$65.00 per half-hour cancellation fee.

Courtesy Reminder Calls

We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone or email prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, pagers, and voice mails, some of our patients may not receive these reminder calls.

If we are unable to speak with you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines. ***Initial*** _____

We appreciate your understanding in our efforts to provide you with an extraordinary dental experience.

Patient Signature: _____

Guardian Signature: _____

Date: _____



WELCOME TO OUR PRACTICE

We would like to take this opportunity to explain a few of our policies and procedures to you.

Appointments

Please be on time to your appointments and arrive a few minutes early. This time is reserved for you. If you arrive late to your appointment, there is a possibility that the office will have to reschedule your appointment so as to not inconvenience other patients.

Please confirm your intention to arrive for your appointment. You will receive a confirmation call one to two days prior to your appointment. It's important that you confirm this appointment so your appointment date and time is held for you. If you don't speak directly with Reception, please leave a message on the answering machine. It will be picked up the next business day.

Our office has a **Failed Appointment Fee of \$65.00** if 48-hour notice is not given. Failed appointments are a problem for everyone. They delay your treatment and they prevent another patient who may be in need of an appointment to come in your place. To eliminate potential problems, we will be strictly enforcing the following policies: If two appointments are missed or cancelled with less than a 48 hour notice, only same day appointments will be made, subject to availability. If four appointments are missed or cancelled with less than a 48 hour notice, the patient may be, at the practice's discretion, dismissed from the practice.

Accounting

Our office offers the following arrangements: cash, check, MasterCard, Visa, Discover, outside financing through CareCredit (o.a.c.) and payments split up during the course of treatment- with the payments ending when the treatment is complete. As a courtesy to our insurance patients, we will bill your insurance, however, the balance due is ultimately your responsibility. If, after 60 days, we do not receive reimbursement from your insurance company, the balance will automatically be transferred to you. There is a 1.5% monthly finance charge on any balances that we carry. Please make sure that the insurance information you give us is accurate. We can not be responsible for any incorrect insurance information presented to our office. Due to the large number of dental plans, we cannot guarantee what an

insurance company will reimburse. Our calculations are based on the current information each insurance company provides us. If there are any discrepancies in the coverage amounts paid by an insurance company on your behalf, we will either bill you the difference or credit your account for any overpayment.

Things you should also know

It can't be stressed enoughregular exams are essential in maintaining a healthy mouth. If your goal is to maintain your teeth, regular exams must be made a priority in your life.

Putting off biyearly exams often leads to worse problems down the line. It is always difficult to see patients decline their biyearly exam for one reason or another because we usually end up seeing them later with more serious problems which require more extensive treatment. **It ALWAYS costs more to wait, so your best bet is to get regular exams!**

Please Help us help you

Please check any of the following procedures that you would be interested in talking with our dental team about:

- 1. Nitrous Oxide - " laughing gas " to make dental treatment more pleasant
- 2. Implants - permanently replace missing teeth
- 3. Braces - straighten teeth with Invisalign or traditional braces
- 4. Whitening - up to 9 shades lighter in a single appointment
- 5. Lumineers - Make-over your smile with no shots & no drilling

We are pleased that you have chosen our office for your dental needs. We look forward to giving you healthy teeth and caring for you and your family.

Patient Signature: _____ Date: _____

welcome

PATIENT NUMBER

Date

Patient's Name Last First Initial Date of Birth Male Female

If Child: Parent's Name

How do you wish to be addressed Single Married Separated Divorced Widowed Minor

Residence - Street

City State Zip

Business Address

Telephone: Res. Bus.

Fax Cell Phone #

eMail

Patient/Parent Employed By

Present Position

How Long Held

Spouse/Parent Name

Spouse Employed By

Present Position

How Long Held

Who is Responsible for this account

Drivers License No.

Method of Payment Insurance Cash Credit Card

Purpose of Call

Other Family Members in this Practice

Whom may we thank for this referral

Patient/parent Social Security No.

Spouse/Parent Social Security No.

Someone to notify in case of emergency not living with you

Dental Insurance 1st Coverage

Employee Name Date of Birth Employer Name Yrs. Name of Insurance Co. Address City State Zip Telephone Program or policy # Social Security No. Union Local or Group

Dental Insurance 2nd Coverage

Employee Name Date of Birth Employer Name Yrs. Name of Insurance Co. Address City State Zip Telephone Program or policy # Social Security No. Union Local or Group

RELEASE: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carder or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments 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, in whole or in pad by my dental care payor. I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE DATE

REGISTRATION



Patient Number grid

PATIENT NUMBER

Patient's Name _____ First _____ Initial _____ Date of Birth _____

- 1. Purpose of initial visit
2. Are you aware of a problem?
3. How long since your last dental visit?
4. What was done at that time?
5. Previous dentist's name
Address: _____ Tel. _____
6. When was the last time your teeth were cleaned?

COMMENTS

Large empty box for patient comments

- CLICK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits?
8. Were dental x-rays taken?
9. Have you lost any teeth or have any teeth been removed?
10. Have they been replaced?
11. How have they been replaced?
12. Are you unhappy with the replacement?
13. Would you like to know about permanent replacements?
14. Have you ever had any problems or complications with previous dental treatment?
15. Do you clench or grind your teeth?
16. Does your jaw click or pop?
17. Have you experienced any pain or soreness in the muscles or your face or around your ear?
18. Do you have frequent headaches, neckaches or shoulder aches?
19. Does food get caught in your teeth?
20. Are any of your teeth sensitive to:
21. Do your gums bleed or hurt?
22. How often do you brush your teeth?
23. Do you use dental floss?
24. Are any of your teeth loose, tipped, shifted or chipped?
25. Are you unhappy with the appearance of your teeth?
26. How do you feel about your teeth in general?
27. Do you feel your breath is offensive at times?
28. Have you ever had gum treatment or surgery?
29. Have you had any orthodontic work?
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
31. Do you have any questions or concerns?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST. box

MED.ALERT box

DENTAL HISTORY

_____|_____|_____|_____|_____|_____|_____|_____|

PATIENT NUMBER

welcome

Patient's Name _____
Last

First _____ Initial _____ Date of Birth _____

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW ON THE LINE AFTER THE QUESTION

COMMENTS

1. Physician's Name _____
Address _____
City _____ State _____ Zip _____ Tel _____
2. Are you under a physician's care? _____ YES NO
Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? _____ YES NO
(if yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? _____ YES NO
6. Are you allergic to any medications or substances? (please list) _____ YES NO
7. Do you have any other allergies or hives? _____ YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? _____ YES NO
9. Are you sensitive to any metals or latex? _____ YES NO
10. Are you pregnant or suspect you may be? _____ YES NO
11. Do you use any birth control medications? _____ YES NO
12. Have you ever been treated for or been told you might have heart disease? _____ YES NO
13. Do you have a pacemaker or an artificial heart valve implant? _____ YES NO
14. Have you ever had rheumatic fever? _____ YES NO
15. Are you aware of any heart murmurs? _____ YES NO
16. Do you have high or low blood pressure? (please circle) _____ YES NO
17. Have you ever had a serious illness or major surgery? _____ YES NO
If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? _____ YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? _____ YES NO
20. Do you have any artificial joints/prosthesis? _____ YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? _____ YES NO
22. Have you ever bled excessively after being cut or injured? _____ YES NO
23. Do you have any stomach problems? _____ YES NO
24. Do you have any kidney problems? _____ YES NO
25. Do you have any liver problems? _____ YES NO
26. Are you diabetic? _____ YES NO
27. Do you have fainting or dizzy spells? _____ YES NO
28. Do you have asthma? _____ YES NO
29. Do you have epilepsy or seizure disorders? _____ YES NO
30. Do you or have you had venereal disease? _____ YES NO
31. Have you tested HIV positive? _____ YES NO
32. Do you have AIDS? _____ YES NO
33. Have you had or do you test positive for hepatitis? _____ YES NO
34. Do you or have you had T.B.? _____ YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? _____ YES NO
36. Do you consume alcoholic beverages? _____ YES NO
37. Do you habitually use controlled substances? _____ YES NO
38. Have you had psychiatric treatment? _____ YES NO
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? _____ YES NO
40. Do you have any disease condition, or problem not listed? If so, explain _____

41. Is there anything else we should know about your health that we have not covered in this form? _____
42. Would you like to speak to the Doctor privately about any problem? _____ YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED.ALERT

MEDICAL HISTORY



The Winning Smiles Dental Offices

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(800) 243-4675

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form:

Describe the reason why the individual would not sign this form:

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

**ACKNOWLEDGEMENT OF RECEIPT OF
PRIVACY PRACTICES NOTICE**