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

PATIENT NUMBER

(800) 243-4675

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 Go. _____
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 Go. _____
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 _____

Form No. TI1OR

REGISTRATION

welcome

PATIENT NUMBER

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

Parents's Guardian's Name _____

DENTAL HISTORY - CHECK THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ☐ YES ☐ NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ☐ YES ☐ NO
4. Does your child eat between meals? ☐ YES ☐ NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ☐ YES ☐ NO
6. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
7. How does your child receive Fluoride?
   ☐ Community water level ____ ppm ☐ Well water level ____ ppm
   ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
8. Have any cavities been noted in the past? ☐ YES ☐ NO
9. Were any teeth (baby or permanent) removed by extraction? ☐ YES ☐ NO
   Was it suggested that the space be maintained ... ☐ YES ☐ NO
   Was an appliance placed ☐ YES ☐ NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? ☐ YES ☐ NO
    If so describe _____
11. Has your child had any problem with dental treatment in the past? ☐ YES ☐ NO
12. Has anyone in the family, including parents, had orthodontics? ☐ YES ☐ NO
13. Has your child ever received a local anesthetic? ☐ YES ☐ NO
14. Has your child ever had occlusal sealants? ☐ YES ☐ NO
15. Does your child think there is anything wrong with his/her teeth? ☐ YES ☐ NO

MEDICAL HISTORY

1. Does your child have a health problem? ☐ YES ☐ NO
2. Is your child under the care of physician? ☐ YES ☐ NO
   If yes, since when and why? _____
3. Name of physician _____ _____ phone
4. Is your child receiving any medication? ☐ YES ☐ NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? ☐ YES ☐ NO
6. Is your child allergic to or sensitive to any metals or latex? ☐ YES ☐ NO
7. Does your child have other allergies? ☐ YES ☐ NO
8. Has your child had any serious illness? ☐ YES ☐ NO
   When _____ What _____
9. Has your child ever had surgery? ☐ YES ☐ NO
10. Does your child have a heart murmur? ☐ YES ☐ NO
11. Is surgery contemplated? ☐ YES ☐ NO
12. Does your child experience severe or prolongated bleeding? ☐ YES ☐ NO
13. Does your child have AIDS or has he/she tested HIV positive? ☐ YES ☐ NO
14. Has your child tested positive for hepatitis? ☐ YES ☐ NO
15. Is your child subject to nervous disorders? ☐ YES ☐ NO
    ☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Leaming problems?
16. Does your child have frequent headaches? ☐ YES ☐ NO
17. Has your child had history of: (Check appropriate responses)

☐ Diabetes	☐ Cerebral palsy	☐ Infections
☐ Head trouble	☐ Liver problems	☐ Speech impairments
☐ Asthma	☐ Congenital birth defects	☐ Hearing loss
☐ Kidney infection	☐ Mental retardation	
☐ Rheumatic fever	☐ Eyesight problems	
☐ Epilepsy	☐ Cancer	

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE:

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTISTS SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

Form No. T131CDM

The Winning Smiles Dental Offices

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