

Rhett Family Dental

2102 5th Street North Suite 2 • Columbus, MS 39705

(662)328-6953

Welcome to our Practice

Chart#:

FOR OFFICE USE ONLY

Patient Name:

_____ Last

_____ First

_____ MI

_____ Preferred Name

Title:

Gender:

Male Female

_____ Mr/Ms/Mrs/etc

Family Status:

Married Single Child Other

Birth Date:

SS#:

Prev. Visit:

Email Address:

Best time to call:

Phone:

_____ Home

_____ Mobile

_____ Work

_____ Ext

_____ Fax

_____ Other

Address:

_____ Address 1

_____ Address 2

_____ City

_____ State

_____ Zip Code

The following is for:

the patient the person responsible for payment both not applicable

Employer Name:

Phone:

Employer Address:

_____ Address 1

_____ Address 2

_____ City

_____ State

_____ Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Allergy: Bactrim | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Doxycyclin | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Keflex | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | | |

- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> A smoker or smoked previously |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

If any condition or alerts selected above needs further clarification, please explain below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List all medications, supplements, and/or vitamins taken within the last two years:

Dental Information

How would you rate the condition of your mouth?

- Excellent Good Fair Poor

Previous Dentist name and how long you have been a patient there:

Date of most recent dental exam:

Date of most recent dental x-rays:

I routinely see my dentist every:

- 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

What is your immediate concern?

Personal History, Check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Had an unfavorable dental experience | <input type="checkbox"/> Had complications from past dental treatment | <input type="checkbox"/> Had trouble getting numb |
| <input type="checkbox"/> Had any reactions to local anesthetic | <input type="checkbox"/> Had/have braces, orthodontic treatment | <input type="checkbox"/> Had your bite adjusted |
| <input type="checkbox"/> Had any teeth removed | | |

If any of the checked boxes need further explanation, please describe:

Dental Practice Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

* By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy.

Notice of Privacy Practices Acknowledgment.

The privacy of your health information is important to us. Our Notice of Privacy Practices describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices.

By checking this box, I acknowledge that I have received a copy of the dental practice's Notice of Privacy Practices.

Signature of patient, parent, or guardian (responsible party):

Signature _____

Date _____

Name and relationship to patient:

Response Date: _____