Magnolia Family Dental Care

112 South Maple Street
Ridgeland, MS 39157

PATIENT INFORMATION (CONFIDENTIAL)

Male ☐ Female ☐

Name: ______________________ Preferred Name: ______________ Birthdate: ____________

SS#: ________________ Check a Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: ______________________ City: ____________ State: ________ Zip: ________

E-mail: ______________________ Home #: ______________ Cell #: ______________

If Student, Name of School/College: ____________________ City: ______________ State: ______

Employer: __________________________ Work #: ______________

Employer's Address: ____________________ City: ______________ State: ______ Zip: ______

Referred By: __________________________

RESPONSIBLE PARTY (if different than above)

Name of Person Responsible Account: ____________________ Relationship to Patient: ____________

Address: ____

Street Apt. # City State Zip Code

Home #: ______________ Cell #: ______________ Work #: ______________

E-mail: ______________________ SS#: ______________ Birthdate: ______________

Employer: ______________________________ D/L#: ______________

INSURANCE INFORMATION

Subscriber Name: ______________________ Birthdate: ____________ SS #: ______________

Insurance Company Name: ______________________ Subscriber ID#: ______________

Group Name: ______________________ Group #: ______________

Do you have any additional insurance? ☐ Yes ☐ No **If yes, Complete the following:**

Subscriber Name: ______________________ Birthdate: ____________ SS #: ______________

Insurance Company Name: ______________________ Subscriber ID #: ______________

Group Name: ______________________ Group #: ______________

Insurance: ***Please note that your insurance policy is a contract between you and your insurance carrier. It is your responsibility to understand your plan benefits.*** Your dental plan is designed to share in your dental costs and the designated percentages covered may not be equal to that portion of the actual fee charge. As a courtesy to you, we will be glad to prepare and submit your insurance claims. However, any follow up after 60 days will become patient's/responsible party's responsibility. The patient/responsible party is ultimately responsible for the bill and/or any unpaid balance after insurance has paid.

CONSENT FOR TREATMENT

I hereby grant authority to Dr. Casey Heitzmann and/or Dr. Emily Heitzmann, the dentist in charge of my care, to perform such operations as may be deemed necessary in the diagnosis and treatment of my case.

SIGNATURE: ______________________________ **DATE:** ______________________

Financial and Appointment Policy

Appointments: Your appointment time has been reserved specifically to meet your dental needs for that visit; therefore, as a courtesy to Dr. Heitzmann and his staff, please give us at least a 24 hour notice if you are not able to keep your appointment. That will allow us enough time to give your reservation to another patient. ***There is a $40 fee for missed appointments without a 24 hour notice.***

Payment Policy: Payment in full is due at the time of service, unless other financial arrangements have been made prior to the date of the appointment. If you have insurance coverage, your estimated portion will be expected at the time of service. We accept cash, check, all major credit cards, and Care Credit. Returned Checks will be subject to a $30.00 returned check fee.

Treatment for minor children (under age 16): Unless other arrangements have been made prior to appointment, the minor child's parent(s) or legal guardian must accompany the child to their appointment.

Please sign if you understand and agree to the above statements:

Signature: ____ Date: ___________________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (HIPPA)

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practice by providing you with a Notice of Privacy Practices. Our Notice is available online. If you would prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practice has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature: ____ Date: __________________________________

You may discuss my dental treatment with: ____

____

You may discuss my finances with: ____

____

MEDICAL HISTORY INFORMATION

Patient Name: ______________________________ Date of Birth: ____________

1) Physician's Name: ____________________ Phone #: ________________ Date of Last Exam: ______________

2) Which Pharmacy do you use: ________________________________ Phone #: ____________________

3) **Women:** Are you pregnant or trying to get pregnant? ☐ Yes ☐ No **If yes, # of Weeks**: _____ Breast Feeding? ☐ Yes ☐ No

Do you use Birth Control? ☐ Yes ☐ No Are you receiving Hormone Therapy? ☐ Yes ☐ No

****Some antibiotics may cause birth control to be less effective.** *Please **Initial** if you understand previous statement.* _____

4) Are you allergic to or have you had an allergic reaction to any of the following (*please check all that apply*):

☐ Local Anesthetic	☐ Clindamycin	☐ Penicillin	☐ Iodine	☐ Codeine	☐ Jewelry/Metals
☐ Erythromycin	☐ Tetracycline	☐ Aspirin	☐ Sulfa	☐ Latex	Other: ____________

5) Are you taking or have you ever taken any of the following "Bisphosphonate" medications (please circle if yes):

☐ Actonel	☐ Aredia	☐ Bonefos	☐ Boniva	☐ Didronel	☐ Fosamax	☐ Reclast	☐ Skelid	☐ Zometa

For how long? ______________________ When did you stop? ________________________

6) Please list other medications you are currently taking and dosages:

____

7) Do you smoke or use tobacco products? ☐ Yes ☐ No If yes, please explain: ______________________

8) Do you consume alcohol? ☐ Yes ☐ No If yes, approximately how many alcoholic beverages per week? __________

9) Do you have, or have you had, any of the following (please check all that apply)?

☐ AIDS/HIV/ARC	☐ Cough, persistent/bloody	☐ High Cholesterol	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Shingles
☐ Arthritis	☐ Emphysema	☐ Liver Disease/Jaundice	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Epilepsy	☐ Low Blood Pressure	☐ Sinus Problems
☐ Artificial Joints	☐ Fainting/Dizziness	☐ Migraine Headaches	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Nervous Disorders	☐ Swollen Feet/Ankles/Glands
☐ Back Problems	☐ Head Injuries	☐ Pacemaker	☐ Thyroid Problems
☐ Bacterial Endocarditis	☐ Heart Disease	☐ Psychiatric Care	☐ Tuberculosis
☐ Cancer (Type: _____)	☐ Heart Murmur	☐ Radiation/Chemotherapy	☐ Tumor on Head/Neck
☐ Chemical Dependency	☐ Hepatitis (Type____)	☐ Respiratory Disease	☐ Ulcer
☐ Congenital Heart Lesions	☐ Herpes	☐ Rheumatic Fever	☐ Venereal Disease
☐ Cortisone Treatments	☐ High Blood Pressure	☐ Rheumatism	☐ Other ______________

DENTAL HISTORY INFORMATION

1) Previous Dentist: ______________________________ Phone Number: __________________

2) Date of last dental exam: ____________________ Date of last dental x-rays: __________________

3) How often do you brush: ____________________ How often do you floss: ____________________

4) Do you have, or have you had, any of the following (please check all that apply)?

☐ Bad Breath	☐ Collect Food Between Teeth	☐ Lip/Cheek Biting	☐ Periodontal Treatment
☐ Bleeding Gums	☐ Dry Mouth	☐ Loose/Broken Teeth	☐ Sensitivity to Cold
☐ Blisters on Lips/Mouth	☐ Fingernail Biting	☐ Mouth Breathing	☐ Sensitivity to Hot
☐ Burning Sensation of Tongue	☐ Grinding Teeth	☐ Pain When Brushing	☐ Sensitivity to Sweets
☐ Chew on One Side	☐ Gums Swollen/Tender	☐ Orthodontic Treatment	☐ Sensitivity When Biting
☐ Clicking/Popping Jaw	☐ Jaw Pain/Tiredness	☐ Pain Around Ears	Other: ______________

I understand the importance of a truthful health/dental history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_________________________________ ______________________

Signature of Patient/Legal Guardian Date