Magnolia Family Dental Care

112 South Maple Street
Ridgeland, MS 39157

PATIENT INFORMATION (CONFIDENTIAL)

Date: _____

Name: _____ Preferred Name: _____ ☐ Male ☐ Female

Social Security #: _____ Birthdate: _____ Referred By: _____

Address: _____

Street Apt. # City State Zip Code

Father's Name: _____ Phone #: _____ Birthdate: _____

Mother's Name: _____ Phone #: _____ Birthdate: _____

Father's Email: _____ Mother's Email: _____

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

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.

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.***

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: _____

_____

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CHILD'S DENTAL & MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Dental History

What is the reason for today's visit? _____
Is this the child's first visit to a dentist? ☐ Yes ☐ No If no, when was the last dental visit? _____
Former dentist, if any? _____ _____ Phone _____
Has the child ever had any dental X-rays? ☐ Yes ☐ No If yes, when? _____
Has your child ever had any injuries to the mouth, head or teeth? _____
Has your child ever had any problem with dental treatment in the past? _____
Has your child ever had any orthodontic treatment? _____
What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water
Has your child ever received fluoride supplements? ☐ Yes ☐ No If yes, what age? _____
How many times are the child's teeth brushed per day? _____ When? _____
Are the child's teeth being flossed? ☐ Yes ☐ No If yes, how often? _____
Has the child sucked his or her thumb, fingers, or pacifier? ☐ Yes ☐ No Does the habit still exist? _____
Does the child grind his or her teeth? ☐ Yes ☐ No
Are the child's immunizations current? ☐ Yes ☐ No

Medical History

1.) Is your child taking any prescription and/ or over the counter medications? ☐ No ☐ Yes
If yes, please list _____
2.) Is your child allergic to any medications? ☐ No ☐ Yes
If yes, please list _____
3.) Is your child allergic to any foods or materials? ☐ No ☐ Yes
If yes, please list _____
4.) Has your child been hospitalized? ☐ No ☐ Yes
When? _____ Reason? _____

Has your child had any history or ever been diagnosed with any of the following:

☐ Anemia
☐ Allergy/ Hay Fever
☐ Artificial Heart Valve
☐ Artificial Joint/ Limb
☐ Asthma
☐ ADD/ ADHD
☐ Autism
☐ Behavior/ Learning Disabilities
☐ Epilepsy/ Seizure
☐ Birth Defects
☐ Bleeding Disorder
☐ Bone/ Joint/ Orthopedic Problems
☐ Brain Injury
☐ Cancer, Type _____
☐ Cerebral Palsy
☐ Chemotherapy
☐ Chicken Pox
☐ Chronic Sinusitis
☐ Cleft Lip/ Palate
☐ Diabetes
☐ Digestive Disturbances
☐ Ear Infection
☐ Eye Problems
☐ Fainting
☐ Fever Blisters
☐ Growth Problems
☐ Hearing Loss/ Aids
☐ Heart Murmur
☐ Heart Problem
☐ Heart Surgery
☐ Hepatitis
☐ HIV+ / AIDS
☐ Hormonal Disturbances
☐ Kidney Problems
☐ Liver Problems
☐ Measles
☐ Mumps
☐ Nervous Disorders
☐ Pneumonia
☐ RSV
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shunt
☐ Sickle Cell Anemia
☐ Tetanus
☐ Tuberculosis
☐ Other:
_____
_____

Pediatrician/ Physician Name: _____ **Phone:** _____

I understand that the above information will be used for my child's dental health. I have answered the questions to the best of my ability. If further information is needed you may contact my child's health care physician for any other information.

Parent Signature: _____ **Date:** _____