Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Date: _____

SS #: _____

Patient Information

Name _____ Birthdate _____ Phone (___) _____

Address _____ City _____ State _____ Zip _____

Sex ○ M ○ F ○ Married ○ Single ○ Minor ○ Other

E-mail _____ Cell Phone # (___) _____

Employer/School _____ Phone # (___) _____

Employment Address _____

Spouse or Parent's Name _____

How did you hear about us? (For informational purposes) _____

Person to contact in case of emergency _____ Relationship _____

Emergency contact phone # (___) _____

Responsible Party

Name of Person Responsible for Account _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Subcribers Insurance Information

Name of Subcriber _____ Realtionship to Patient _____

Birthdate _____ SS # _____

Employer _____ Address _____

Insurance Company _____ Group # _____

Medical History

Physician's Name _____ Date of last visit _____

Have you ever had serious illnesses or operations? ○YES ○ NO If yes, describe _____

_____

Are you currently taking any blood thinners? ○ YES ○ NO

Have you ever took medication for Osteoporosis ? ○ YES ○ NO

(Women) Are you currently pregnant? ○YES ○ NO If yes, Physician_____

✓ Check if you have or have had any of the following:

○ Anemia	○ Congenital Heart Lesions	○ Hepatitis	○ Scarlet Fever
○ Arthritis, Rheumatism	○ Cortisone Treatments	○ Hernia Repair	○ Shortness of Breath
○ Artificial Heart Valve	○ Cough, Persistent	○ High Blood Pressure	○ Stroke
○ Artificial Joints, Pins, etc.	○ Cough up Blood	○ HIV/ AIDS	○ Thyroid Problems
○ Asthma	○ Diabetes	○ Jaw Pain	○ Tuberculosis
○ Back Problems	○ Epilepsy	○ Kidney Disease	○ Tumors
○ Bleeding Abnormally	○ Fainting	○ Liver Disease	○ Ulcers
○ Blood Disease	○ Glaucoma	○ Mental Disorder	○ Veneral Disease
○ Cancer	○ Hay Fever	○ Mitral Valve Prolapse	
○ Heart Disease	○ Head Injury	○ Pacemaker	
○ Chemical Dependency	○ Heart Murmur	○ Radiation Treatment	
○ Chemotheraphy	○ Heart Valves	○ Respiratory Disease	
○ Circulatory Problems	○ Hemophilia	○ Rheumatic Fever	
○ Dizziness	○ Sinus Problems	○ Rheumatism	

Please list ALL allergies (i.e Penicillin, Latex, Codeine, etc.)

_____

_____

_____

_____

List all medications you are currently taking: _____

_____

_____

Dental History

Reason for today's visit _____ Date of last dental care _____

✓ Check if you had problems with any of the following:

○ Bad breath	○ Grinding teeth	○ Sensitivity to hot
○ Bleeding gums	○ Loose teeth/ broken fillings	○ Sensitivity to sweets
○ Clicking or jaw popping	○ Periodontal treatment	○ Sensitivity when biting
○ Food collection between the teeth	○ Sensitivity to cold	○ Sores or growths in mouth

How often do you floss? _____

How often do you brush? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature X _____ Date: _____

Office Payment Policy and Financial Agreement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services finished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare that patients insurance forms or assist in making collections to the patients account. However, this dental office cannot render services on assumption that our charges will be paid by an insurance company. I understand that the free estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examinations. In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assigned at the time services are rendered. I further agree that the reasonable value of said services shall be billed unless objected by me in writing within the time for payment thereof, I further agree that any breach at any time or condition shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their consent. Any check that bounces will have a $40.00 NSF fee applied to it. Also, a balance unpaid for three (3) months is considered delinquent, in the event that any such amount is placed with our collection agency, you will be responsible for collection fees (50% of the balance owed will be added to the cost being sent to collections). Any attorney fees and court costs will also be the responsibility of the person financially responsible for the account.

Signature of Gurantor or responsible party of payment X _____

Date: _____ Relationship to patient _____

Vicksburg Family Dental 61N

Acknowledgement of Receipt of Notice of Privacy Practices

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have received a copy of this office's Privacy Practices.

Please Print Name: _____

Signature: _____

Date:

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other- Please Specify:

Witness Signature:

Consent for Treatment

1. I hereby authorize Dr. Karla Haik and Dr. Terry Lake Garner or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by any of the following dentist to make a thorough diagnosis of (_____) dental needs.
2. Upon such diagnosis, I authorize Dr. Haik and Dr. Garner to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other, medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.
5. Any check that bounces will have a $40.00 NSF fee applied to it. Also, a balance unpaid for three (3) months is considered delinquent, in the event that any such amount is placed with our collection agency, you will be responsible for collection fees (50% of the balance owed will be added to the cost being sent to collections). Any attorney fees and court costs will also be the responsibility of the person financially responsible for the account.

Signature for Consent_____

Witness

Date