

Welcome

Tracey Douglas, DMD
204 Waterford Square
Madison, MS 39110

To help us get to know you and provide you with the best possible care please fill out this form completely. If you have any questions or concerns, please ask. We will be happy to assist you in any way. Please feel confident that the information contained in this form will be kept confidential.

GENERAL INFORMATION

Name _____ Preferred _____

Address _____

City _____ State _____ Zip Code _____

Phone: Home _____ Work _____ Other _____

Place of Employment _____

SSN _____ Date of Birth _____

Marital Status: Single Married Child Other

Spouse's or Parent's Name _____

SSN _____ Date of Birth _____

Emergency Contact _____ Phone _____

EMAIL ADDRESS _____

Whom May We Thank For Referring You? _____

If person listed above is not responsible for their account, please provide contact information for the responsible party below:

Name _____ Preferred _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Place of Employment _____

SSN _____ Date of Birth _____

Marital Status: Single Married Child Other

Privacy Act Acknowledgement

I have received the Notice of Privacy Practices (HIPAA) and I have been provided an opportunity to review it.

Consent to Treatment

I hereby grant authority to Dr. Tracey Douglas, and/or the dentist in charge of my care, to administer such anesthetics; and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case.

Signed _____ Date _____

Medical History Information

Physician _____ Phone _____ Date of Last Exam _____

1. Are you under medical care now? Yes No
2. Have you been hospitalized for any reason within the last five years? Yes No
If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medication(s) are you taking? _____
4. Have you ever taken pre-medication for dental treatment? Yes No
(Heart murmur, Mitral Valve Prolapse, Artificial Joint Replacement)
5. Do you use any of the following? Tobacco: Yes No
Controlled substances: Yes No

PLEASE CIRCLE YES OR NO IN THE FOLLOWING SECTIONS

6. Do you or have you had any of the following?

| | | | | | |
|-----------------------|-----|----|--------------------|-----|----|
| High Blood Pressure | Yes | No | Fainting/Seizures | Yes | No |
| Heart Attack | Yes | No | Asthma | Yes | No |
| Heart Disease | Yes | No | Epilepsy | Yes | No |
| Cardiac Pacemaker | Yes | No | Leukemia | Yes | No |
| Rheumatic Fever | Yes | No | Diabetes | Yes | No |
| Heart Murmur | Yes | No | Kidney Diseases | Yes | No |
| Angina | Yes | No | AIDS/HIV Infection | Yes | No |
| Mitral Valve Prolapse | Yes | No | Thyroid Problems | Yes | No |
| Stroke | Yes | No | Cancer | Yes | No |
| Emphysema | Yes | No | Hepatitis/Jaundice | Yes | No |
| Respiratory Problems | Yes | No | Liver Disease | Yes | No |

7. Are you allergic to or have you had any reactions to the following?

| | | | | | |
|------------------------|-----|----|----------------------------|-----|----|
| Local Anesthetics | Yes | No | <u>Latex Rubber</u> | Yes | No |
| Penicillin/Antibiotics | Yes | No | Sulfa Drugs | Yes | No |
| Barbiturates | Yes | No | Iodine | Yes | No |
| Aspirin | Yes | No | Any Metals | Yes | No |
| Sedatives | Yes | No | Other | Yes | No |

8. Women Only:

| | | |
|--|-----|----|
| Are you pregnant or think you may be pregnant? | Yes | No |
| Are you nursing? | Yes | No |
| Are you taking oral contraceptives? | Yes | No |

Dental History

- | | | |
|---|-----|----|
| 1. Do your gums bleed while brushing or flossing? | Yes | No |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | Yes | No |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | Yes | No |
| 4. Do you feel any pain in any of your teeth? | Yes | No |
| 5. Do you have lumps or sores in or near your mouth? | Yes | No |
| 6. Have you ever had any head, neck or jaw injury? | Yes | No |
| 7. Have you ever experienced any pain or discomfort? associated with your TMJ area (upper jaw area)? | Yes | No |
| 8. Do you have frequent headaches? | Yes | No |
| 9. Do you clench or grind your teeth? | Yes | No |
| 10. Have you ever had difficult extractions in the past? | Yes | No |
| 11. Do you like your smile? | Yes | No |
| 12. Have you received orthodontic treatment before? | Yes | No |

Authorization and Release

I certify that I have read and understand the above to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be detrimental to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Responsible Party _____

Tracey Douglas, D.M.D.
204 Waterford Square
Madison, MS 39110

FINANCIAL ARRANGEMENTS, DENTAL INSURANCE AND OFFICE POLICY

We are committed to providing you with our best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, or Visa. There is also outside financing available, please ask for additional information. Except on initial visits, you are responsible for the percentages that insurance will not cover. On initial visits, unless we can verify your coverage, you are responsible for the full fee at the time of service.

Returned checks will be charged a \$30.00 NSF fee and outstanding balances older than 30 days will be charged interest at a monthly rate of 1.50%. If you should have an outstanding balance, you will receive a monthly statement from us and payment should be directed to the address on the remittance statement. **A charge of \$50.00 may be made for broken appointments canceled without 48 business hours advance notice.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. This is to notify those utilizing insurance for payment that if the balance of the account is not paid within 30 days, you will be notified that your insurance company has not paid and we will require payment directly from you.
3. We will file the insurance payment as a courtesy, but it is not our responsibility to make certain whether or not they pay. This is your responsibility.
4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a dental care provider, our relationship is with you, not the insurance company. While filing of the insurance claim is a courtesy to you, all charges are your responsibility from the date services are rendered.

If you have any questions about the information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help you.

Signature _____ Date _____