6 Medical Park Dr.
Fulton, MS 38843
(662) 862-7434
www.marquisdentalcenter.com

PATIENT INFORMATION

□ MARRIED □ SINGLE □ MINOR □ STUDENT □ MALE □ FEMALE

NAME:_____
Last First MI PREFERRED NAME

ADDRESS:_____
Street APT # City State Zip

BIRTHDATE: _____ AGE: _____ SS#:_____

HOME PHONE: _____ CELL: _____ EMAIL:_____

PLACE OF EMPLOYMENT: _____ WORK PHONE:_____

EMERGENCY CONTACT/RELATIONSHIP: _____ PHONE:_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? □ Another Patient □ Another Dental/Doctor Office
□ Yellow Pages □ Facebook □ Google □ School □ Work □ Other _____

Name of person or office referring you to our practice:_____

FINANCIAL RESPONSIBLE PARTY (if under 21 MUST be parent or legal guardian)

NAME: _____ RELATIONSHIP TO PATIENT: _____
Last First MI

ADDRESS:_____
Street APT # City State Zip

BIRTHDATE: _____ AGE: _____ SS#:_____

HOME PHONE: _____ CELL: _____ EMAIL:_____

PLACE OF EMPLOYMENT: _____ PHONE:_____

AUTHORIZATION (ALL Patients or Legal Guardians MUST Sign)

I **authorize Marquis Dental Center to perform diagnostic procedures and treatment as they may be necessary for proper dental care. I authorize release of any information concerning mine or my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to Marquis Dental Center, otherwise payable to me. I understand that all insurance co-pay estimates are due the day of service.** I understand that I am responsible for all charges on this account. If no insurance, I understand that all charges are to be paid at the time services are rendered unless prior arrangements have been made. I authorize all insurance payments to be paid directly to Marquis Dental Center. I understand that if the insurance payment is sent to me, it is my responsibility to forward payment on to Marquis Dental Center**. All balances are due within 30 days.** If payment in full or payment arrangements are not made, I understand that my account could go to an outside collection agency on any account over 90 days old. **Finance charges will incur on any account over 60 days old in the amount of 12% annually (1% monthly). If turned over for collections, I understand that my account will be assessed collection and attorney fees in the amount of up to 45%. I understand that my account will be charged a $40 fee for any returned check due to NSF funds or closed accounts.**

X_____ _____
PATIENT OR LEGAL GUARDIAN (IF PATIENT IS UNDER 21) SIGNATURE DATE

MEDICAL HISTORY

NAME OF PRIMARY CARE PHYSICIAN? _____
Have you ever been hospitalized or had a major operation? YES NO
EXPLAIN: _____

Are you ALLERGIC to any medications or substances? YES NO
Please list if not listed below: _____
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex Rubber □ Other

WOMEN: □ Pregnant/Trying to Get Pregnant □ Nursing □ Taking Oral Contraceptives

LIST OF MEDICATIONS:_____
_____

****If you answered yes to any of the starred questions, please call prior to your appointment..PREMEDICATION may be required****

	YES	NO		YES	NO		YES	NO
Heart Disease	□	□	Diabetes	□	□	AIDS/HIV POSTIVE	□	□
Heart Murmur*	□	□	Cold Sores	□	□	Hypoglycemia	□	□
Drug Addiction	□	□	Angina/Chest Pains	□	□	Lung Disease	□	□
Liver Disease	□	□	Heart Attack/Failure	□	□	Breathing Problems	□	□
Hepatitis A/B/C	□	□	Herpes	□	□	Mitral Valve Prolapse*	□	□
Stroke	□	□	Scarlet Fever	□	□	Hay Fever	□	□
Convulsions	□	□	Rheumatic Fever*	□	□	Artificial Heart Valve*	□	□
Sinus Trouble	□	□	Kidney Problems	□	□	Renal Dialysis	□	□
Epilepsy/Seizures	□	□	Pacemaker	□	□	Heart Surgery*	□	□
Anemia	□	□	Emphysema	□	□	Stomach Disease	□	□
Ulcers	□	□	Glaucoma	□	□	Alzheimer's Disease	□	□
High Blood Pressure	□	□	Tuberculosis	□	□	Thyroid	□	□
Pain in Jaw Joint	□	□	Artificial Joints*	□	□	Tumors/Growths	□	□
Allergies (Pollen/Dust)	□	□	Cancer	□	□	Chemotherapy	□	□
Steroid Therapy	□	□	Organ Transplant*	□	□	Nervousness	□	□
Asthma	□	□	Radiation	□	□	Arthritis/Gout	□	□
Rheumatism	□	□	Psychiatric Care	□	□	Fainting/Dizziness	□	□
Excessive Bleeding	□	□	Sleep Apnea	□	□	Other	□	□

Have you ever had any illnesses not checked above? YES NO

EXPLAIN: _____

Do you smoke? YES _____ NO _____ How many packs per day? _____

Do you use any other form of tobacco? YES _____ NO _____ What kind? _____

Number of sodas or sweet drinks per day? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform Marquis Dental Center

X_____ _____
PATIENT OR LEGAL GUARDIAN (IF PATIENT IS UNDER 21) SIGNATURE DATE

DENTAL HISTORY

Name of previous dentist: _____

Date of last dental visit: _____

How long since last cleaning? _____

Reason for changing dentist: _____

Describe your current dental problem: _____

APPREHENSION

Do you experience fear of having dental treatment performed?	YES	NO
Have you had an unpleasant dental experience?	YES	NO
Do you dread the numbing after effects?	YES	NO
Do you feel you need any help overcoming fear?	YES	NO

TEETH PROBLEMS

Are your teeth sensitive to hot, cold, sweets or pressure?	YES	NO
Does food wedge between certain teeth?	YES	NO
Do you have areas that are hard to floss?	YES	NO

GUM PROBLEMS

Do your gums ever bleed when you brush or floss?	YES	NO
Have your gums receded from your teeth?	YES	NO
Do you have bad breath or a bad taste in your mouth?	YES	NO

HEADACHES/FACIAL PAIN

Do you have frequent headaches?	YES	NO
Do you experience popping or clicking upon opening or closing?	YES	NO
Do you experience facial muscle pain while chewing or when you wake up?	YES	NO

YOUR SMILE

Do you think you have a pretty smile?	YES	NO
Are your teeth crooked?	YES	NO
If so, does this bother you?	YES	NO
Have you had any cosmetic dentistry?	YES	NO
Would you like to have whiter teeth?	YES	NO
Do you have any fillings or blemishes on your teeth that make them look bad?	YES	NO

PLEASE LIST ANY CONCERNS THAT YOU WOULD LIKE TO DISCUSS: _____

_____

X_____ _____

PATIENT OR LEGAL GUARDIAN (IF PATIENT IS UNDER 21) SIGNATURE DATE

PATIENTS NAME: _____ **DATE OF BIRTH:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, do hereby give my permission for Marquis Dental Center to discuss any and all medical/dental records and/or bring my child **(if under 21)** for dental care/treatment with the following physician/person in regards to myself or my child **(if under 21):**

_____ _____

_____ _____

_____ _____

_____ _____

***** PLEASE NOTE THAT IF A PERSON IS NOT LISTED ON THIS FORM THAT WE WILL NOT BE ABLE TO DISCUSS ANYTHING ABOUT YOU OR YOUR CHILD. ALSO, IF A CHILD IS A MINOR, ANY PERSON THAT WILL BE BRINGING YOUR CHILD TO THE DENTIST MUST ALSO BE LISTED. IF SOMEONE BRINGS YOUR CHILD AND THEY ARE NOT LISTED, WE WILL NOT BE ABLE TO SEE THEM AND THEY WILL HAVE TO BE RESCHEDULED. IT IS YOUR RESPONSIBILITY TO KEEP THIS LIST UPDATED AS NEEDED. *****

_____
INITIALS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Marquis Dental Center Notice of Privacy Practices.

X_____ _____
SIGNATURE of PATIENT OR LEGAL GUARDIAN (IF PATIENT IS UNDER 21) **DATE**