PEOPLE'S DENTAL, P. A.
110 Hwy 12 West, Suite A
STARKVILLE, MS 39759
662.338.0700

PATIENT LEGAL NAME:_____

PREFERS TO BE CALLED:_____

ADDRESS:_____

CITY, STATE, ZIP CODE:_____

HOME PHONE:_____CELL PHONE:_____

DATE OF BIRTH: _____/_____/_____ SEX: M_____ F_____ SSN:_____

EMAIL ADDRESS:_____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

**EMERGENCY CONTACT**_____ **PHONE NUMBER** _____

## RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

NAME:_____ RELATIONSHIP:_____

ADDRESS(IF DIFFERENT):_____

(2) BEST CURRENT CONTACT PHONE NUMBERS:_____

DATE OF BIRTH: _____/_____/_____ SEX: M_____ F_____ SSN:_____

EMPLOYER NAME & ADDRESS:_____

EMAIL ADDRESS:_____

## PRIMARY INSURANCE INFORMATION

NAME OF INSURED:_____ RELATION TO PATIENT:_____

INSURED SSN:_____ INSURED DATE OF BIRTH:_____

INSURED'S EMPLOYER_____

INSURANCE COMPANY & PHONE NUMBER:_____

ID # ON CARD:_____ GROUP NUMBER:_____

*** I am responsible for all costs associated with my dental treatment.
*** I understand that if a patient misses 3 appointments, they will not be scheduled again.
*** I understand that there is a 24 Hour Confirmation Policy. All appointments must be confirmed within 24 hours of the scheduled appointment time in order to hold the appointment spot.
***I WOULD LIKE TO RECIEVE CORRESPONDENCE VIA EMAIL/TEXT MESSAGE ☐OPT-OUT

SIGNED: _____ DATE: ___/___/___

Please list the name of your primary physician. ◯ NONE Name: _____

Are you under a physician's care now? ◯YES ◯NO If yes: _____

Have you ever been hospitalized or had a major operation? ◯YES ◯NO If yes: _____

Have you ever had a serious head or neck injury? ◯YES ◯NO If yes: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯YES ◯NO If yes: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯YES ◯NO If yes: _____

Do you use tobacco? ◯YES ◯NO If yes: _____

Do you use controlled substances? ◯YES ◯NO If yes: _____

Do you currently take any medications, pills, or drugs? ◯YES ◯NO

If yes, please list **ALL medications**:

Are you...

◯Pregnant/trying to get pregnant? ◯Nursing? ◯Taking Contraceptives

Are you allergic to any of the following?

◯Aspirin ◯Penicillin ◯Codeine ◯Acrylic

◯Metal ◯Latex ◯Sulfa Drugs ◯Local Anesthetics

◯Other Allergy: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | ◯Yes ◯No | Diabetes | ◯Yes ◯No | Hypoglycemia | ◯Yes ◯No | Recent Weight Loss | ◯Yes ◯No |
| Alzheimer's Disease | ◯Yes ◯No | Drug Addiction | ◯Yes ◯No | Irregular Heartbeat | ◯Yes ◯No | Renal Dialysis | ◯Yes ◯No |
| Anaphylaxis | ◯Yes ◯No | Easily Winded | ◯Yes ◯No | Kidney Problems | ◯Yes ◯No | Rheumatic Fever | ◯Yes ◯No |
| Anemia | ◯Yes ◯No | Emphysema | ◯Yes ◯No | Leukemia | ◯Yes ◯No | Rheumatism | ◯Yes ◯No |
| Angina | ◯Yes ◯No | Epilepsy or Seizures | ◯Yes ◯No | Liver Disease | ◯Yes ◯No | Scarlet Fever | ◯Yes ◯No |
| Arthritis/Gout | ◯Yes ◯No | Excessive Bleeding | ◯Yes ◯No | Low Blood Pressure | ◯Yes ◯No | Shingles | ◯Yes ◯No |
| Artificial Heart Valve | ◯Yes ◯No | Fainting Spells/Dizziness | ◯Yes ◯No | Lung Disease | ◯Yes ◯No | Sickle Cell Disease | ◯Yes ◯No |
| Artificial Joint | ◯Yes ◯No | Genital Herpes | ◯Yes ◯No | Mitral Valve Prolapse | ◯Yes ◯No | Sinus Trouble | ◯Yes ◯No |
| Asthma | ◯Yes ◯No | Glaucoma | ◯Yes ◯No | Non-verbal | ◯Yes ◯No | Special Needs | ◯Yes ◯No |
| Autism | ◯Yes ◯No | Heart Attack/Failure | ◯Yes ◯No | Osteoporosis | ◯Yes ◯No | Spina Bifida | ◯Yes ◯No |
| Blood Disease | ◯Yes ◯No | Heart Murmur | ◯Yes ◯No | Pain in Jaw Joints | ◯Yes ◯No | Stomach/Intestinal Disease | ◯Yes ◯No |
| Blood Transfusion | ◯Yes ◯No | Heart Pacemaker | ◯Yes ◯No | Parathyroid Disease | ◯Yes ◯No | Thyroid Disease | ◯Yes ◯No |
| Breathing Problems | ◯Yes ◯No | Heart Trouble/Disease | ◯Yes ◯No | Hypoglycemia | ◯Yes ◯No | Swelling of Limbs | ◯Yes ◯No |
| Bruise Easily | ◯Yes ◯No | Hemophilia | ◯Yes ◯No | Irregular Heartbeat | ◯Yes ◯No | Stroke | ◯Yes ◯No |
| Cancer | ◯Yes ◯No | Hepatitis A | ◯Yes ◯No | Osteoporosis | ◯Yes ◯No | Tonsilitis | ◯Yes ◯No |
| Chemotherapy | ◯Yes ◯No | Hepatitis B or C | ◯Yes ◯No | Pain in Jaw Joints | ◯Yes ◯No | Tuberculosis | ◯Yes ◯No |
| Chest Pains | ◯Yes ◯No | Herpes | ◯Yes ◯No | Parathyroid Disease | ◯Yes ◯No | Tumors or Growths | ◯Yes ◯No |
| Cold Sores/Fever Blisters | ◯Yes ◯No | High Blood Pressure | ◯Yes ◯No | Periodontal Disease | ◯Yes ◯No | Ulcers | ◯Yes ◯No |
| Congenital Heart Disorder | ◯Yes ◯No | High Cholesterol | ◯Yes ◯No | Psychiatric Care | ◯Yes ◯No | Venereal Disease | ◯Yes ◯No |
| Convulsions | ◯Yes ◯No | Hives or Rash | ◯Yes ◯No | Radiation Treatment | ◯Yes ◯No | Wheelchair | ◯Yes ◯No |

Have you ever had any serious illness or special needs not listed above?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X_____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**PATIENT NAME**:_____ **DATE OF BIRTH**: _____

**The above named person must indicated when this authorization is to expire:**

___ Six months ___ Three years
___ One year ___ On date: _____

**The person named above is or has been a patient of**

People's Dental, P. A.
110 Hwy 12 West, Suite A
Starkville, MS 39759
(p) 662.338.0700
(f) 662.338.0710

**The person named above hereby authorizes People's Dental, P. A. to**
___Request health information from
___Send health information to
___Discuss health information with
___Not discuss health information with anyone

**The person named above authorizes information to be requested or released by**

_____ _____
_____ _____

**Scope**
The following information may be disclosed:
___Any and all information
___Date of service _____ to _____
___ Information related to_____

___I do not wish to disclose any information to anyone.

**Authorization**

_____ _____
Printed name of Patient or Authorized Representative Date

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Signature of Witness Date

If not signed by the patient, indicated relationship of authorizing person to patient:
___Parent or guardian of minor child
___Guardian or conservator of conserved patient

# Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations. But that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of _____, 20____.

Print Name: _____

Relationship to Patient:_____

Sign Name: _____

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