Patient Information

Today's date: ___________________

Patient Name: ____ **I prefer to be called** ______________
Last First MI

Address: ____
Street Apartment #

____
City State Zip Code

Sex: ☐ Male ☐ Female **Check one:** ☐ Minor child** ☐ Single ☐ Married/Partnered

Patient's Date of Birth_______________________ **Social Security #:** _____________________________________

Phone (Home): ____________________ **(Cell)** _______________________ **Work phone:** __________________**ext** ____

Employer: ____ **Occupation:** ______________________________

Work Address: ____
Street City State Zip Code

Email address:____ **Driver's License: State** ______ **#** __________________

In case of emergency, please contact: ____ **Phone:** __________________

**Parent/Guardian Information for Minor Children

Parent/Guardian's name _______________________________________ Relationship to child _______________________

Address, if different from above ____

Phone (Home): ____________________ (Cell) ________________________ Work phone: __________________ext ____

Information for Military Members

Sponsor's name _______________________________________ Date of Birth _____________________________________

Social Security # _______________________________________ Phone: ____

Unit/Unit Address ____ Work phone __________________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient** ☐ Our Website ☐ Yellow Pages
☐ Another dentist ☐ Internet Search ☐ Insurance Company Website ☐ TV commercial
☐ South MS Living Magazine ☐ Mississippi Magazine Other ____

**Name of person or office referring you to our practice:____

Authorization and Consent

General Consent for Treatment

I agree and consent to a dental examination/treatment by Dr. Grafton Teets, DDS. I also understand that additional diagnostic procedures and treatment may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

Release of Information

I authorize Dr. Grafton Teets, DDS under the name Biloxi Family Dental Care to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Grafton Teets, DDS under the name Biloxi Family Dental Care.

Photography Release

I authorize Dr. Grafton Teets, DDS under the name Biloxi Family Dental Care to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options (as you may be shown photographs for the same reason).

Appointment Policy/Financial Policy (Please see your copy for details.)

Appointments: We will contact you at least 48 hours in advance to confirm your appointment. **Please call the office or respond via text or e-mail to confirm your appointment.** *We may not be able to hold your appointment time if we are unable to confirm your appointment.* We ask for **48 hours notice to reschedule or cancel an appointment.** Multiple no-show or late cancellations may result in an additional charge. *We cannot accept a cancellation/rescheduling request via text message or e-mail.*

Financial Policy: Payments including insurance cost shares are due at the time of service. Please see the Financial Policy for details on insurance, overdue accounts and payment plans.

My signature acknowledges that:

________*I have read and understand the office policy regarding appointments.*

________*I have read and will comply with the office Financial Policy.*

________*I understand and agree to the General Consent to Treatment.*

________*I authorize the Release of Information.*

________*I assign my insurance benefits to Biloxi Family Dental Care.*

________*Photographs taken of me may be shown to other patients.*

________*I have been offered a choice to read or receive a copy of the Notice of Privacy Practices.*

________*I understand that I must give 48 hours notice to cancel or reschedule an appointment.*

________*I understand that multiple rescheduled or cancelled appointments may result in an additional charge (minimum $50) that would need to be paid prior to scheduling future appointments.*

____ ______________________

Signature of Patient, Parent or Guardian Date

Biloxi Family Dental Care

Dental History

Date of Last Dental Visit: ________________

What is the reason for today's visit: ☐ check-up/cleaning ☐ pain/swelling ☐ Other: ________________________________

Are you experiencing any of the following symptoms?

__ Sensitive teeth
__ Bleeding gums
__ Burning sensation
__ Mouth breathing
__ Migraines
__ Sore jaw
__ Difficulty chewing
__ Abcess
__ Cheek biting
__ Headaches
__ Toothache
__ Receeding gums
__ Difficulty swallowing
__ Sore gums
__ neck pain
__ ear pain
__ Dry mouth
__ Bad breath
__ Sinus problems
__ Calculus/tater build up
__ Clenching/Grinding

Have you had any complications or negative experiences associated with previous dental treatment? ☐ **Yes** ☐ **No**

If yes, please explain. ____

Generally, how have you felt about your previous dental appointments?

__ Very anxious /afraid __ Somewhat anxious/afraid __ Don't care one way or the other __ Look forward to it

Do you clench or grind your teeth in the daytime or at night? **__ Yes __ No**

If yes, do you wear an appliance? ______ If yes, how long? _________________

Have you experienced injuries to your teeth, face or jaw? **__ Yes __ No**

If yes, please explain. ____

Have you experienced any of the following?

__ Scaling and root planning of teeth
__ Tooth extractions
__ Dental implants
__ Head and neck radiation
__ Gum surgery
__ Orthodontics/braces
__ Jaw surgery
__ Prolonged bleeding after dental treatment
__ Severe pains of face and head
__ Reaction to an injection
__ Root canals

My Dental Goals

Please choose one. At this time, I am interested in

_____ emergency care for the relief of pain and/or cosmetic embarrassment only
_____ becoming an established patient to prevent disease/decay and to repair existing problems
_____ cosmetic dentistry after I have completed necessary treatment

Smile Analysis

- Do you like the appearance of your smile? ☐ Yes ☐ No
- If not, please explain what is it about your smile that you would like to change? _______________

____

- What are your goals for your smile? ____
- Are your teeth all in alignment (straight)? ☐ Yes ☐ No
- Do you have spaces that you don't like? ☐ Yes ☐ No
- Do you like the color of your teeth? ☐ Yes ☐ No
- Do you like the shape of your teeth? ☐ Yes ☐ No
- Are there old fillings or dental work that you do not like the appearance of? ☐ Yes ☐ No

Biloxi Family Dental Care

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Acid reflux
☐ AIDS/HIV
☐ ADD/ADHD
☐ Alcohol abuse
☐ Seasonal allergies
☐ Allergy: Codeine
☐ Allergy: Erythromycin
☐ Allergy: Latex
☐ Allergy: Penicillin
☐ Allergy: Other
____
____
____
☐ Anemia
☐ Asthma
☐ Back pain
☐ Bleeding/clotting disorder

☐ Blood disease
☐ Cancer
☐ Chemotherapy
☐ Cold sores/herpes
☐ Diabetes Type **I** or **II**
☐ Drug abuse
☐ Dry mouth
☐ Eating disorder
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Head injuries
☐ Hemophilia
☐ Hepatitis
☐ Heart disease
☐ Heart murmur
☐ Mitral valve prolapse

☐ High blood pressure
☐ Jaundice
☐ Joint / valve replacement
☐ Kidney disease
☐ Liver disease
☐ Mental health disorder
☐ Migraines/headaches
☐ Nervous disorder
☐ Osteoporosis
☐ Pace maker
☐ Radiation treatment
☐ Respiratory problems
☐ Rheumatic fever
☐ Sickle Cell Disease/Trait
☐ Sinus problems
☐ Sleep apnea
☐ Stomach problems

☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers

☐ Pregnant?
If yes, due date _______

☐ Other (please list)
____
____
____

Are you currently taking any medication? ☐ **Yes** ☐ **No** (if yes, please list including over-the-counter meds)

____

____

Do you take a blood thinner? ☐ **Yes** ☐ **No**

Are you currently undergoing chemo or radiation therapy? ☐ **Yes** ☐ **No**

- **Are you now under the care of a physician?** ☐ **Yes** ☐ **No**

If yes, please explain:____

- **Name of Physician:** ______________________________________ **Phone:**____________________

- **Do you smoke or use smokeless tobacco?** ☐ **Yes** ☐ **No**
- **Do you use e-cigarettes?** ☐ **Yes** ☐ **No**

Are you interested in quitting? ☐ **Yes** ☐ **No** ☐ **Not at this time**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist/staff at the next appointment without fail.

________________________________ ______________________________ ____________

printed name **Signature of patient** **date**

ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES

I, ____, have
(printed name)

☐ **received a copy of this office's Notice of Privacy Practices**

or

☐ **read the Notice but declined a copy**

____ ______________
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 acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (specify) ____**

Created 9/20/2013