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:_____

Biloxi Family Dental Care

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

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

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

Biloxi Family Dental Care

Financial Policy

Payment: Payment is due at the time of service.

Payment options: Cash, personal check, credit cards, debit cards, and dental insurance.

Dental Insurance:

- Dental insurance is a means of helping to pay for dental treatment. Dental insurance pays at various percentages for services depending on the provisions of your plan. **Payment of your cost share (which may include your annual deductible) is due at the time of service.**

- **As a courtesy**, we will file your insurance, speak on your behalf to the insurance company, and accept any assignment of benefits that your insurance company will allow.

- We will **estimate** your patient portion by considering deductibles, maximums, and other information provided by your insurance company. The estimate is good for 3 months from the date of your visit.

- Please understand that your insurance is a contract between you and your dental insurance company. The insurance company will not guarantee payment; therefore, patients are directly responsible for all charges. **If your insurance pays less than our estimate, you are responsible for the unpaid balance.**

Overdue accounts: A monthly finance charge of 1.5% will be applied to balances more than 30 days old. Accounts with balances over 60 days will be turned over to a collection agency or to Justice Court to begin the wage garnishment process. You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency fees (40%), court fees, and/or attorney fees).

Credit Cards: We accept American Express, Discover, MasterCard, Visa, CareCredit and debit cards. We also offer SR Pay which allows you to pay from a link that we text to your Smartphone.

Extended Payments:

For patients who desire a monthly payment plan, we offer CareCredit.

- With CareCredit, there are no application fees, no down payment is necessary, and the loan can be **interest-free for up to 12 months.** CareCredit will run a credit check. We can provide you with an application or apply online for you while you are here in the office.

I have read this financial policy. I understand and agree to the terms stated above.

_____ _____ **Date:** _____

Printed name of Patient Signature of Patient or Responsible Party

Revised 2/18/2022

Biloxi Family Dental Care

Broken Appointment Agreement

Our policy requires:

- **Timely cancellations:** If you need to cancel or reschedule your appointment, you must give us at least 48-hours notice. A cancellation made with less than 48-hours notice will be considered a broken appointment.

  ☐ Initials

- **Appointment Confirmation:** You must confirm your appointments. You may call the practice or respond to an e-mail or text message. If you need to make a change to a scheduled appointment, you must call. We may not be able to hold your appointment time if you don't confirm.

  ☐ Initials

- **On-time Arrivals:** Please understand that arriving after your appointment time may result in rescheduling your appointment. If so, it will count as a broken appointment. Please let us know as soon as possible that you cannot be on time. If it doesn't interfere with another patient's appointment, we will be happy to accommodate you.

  ☐ Initials

- **Compliance:** Patients are allowed ONE broken appointment. After the second broken appointment, your future appointments will be subject to the results outlined in our policy.

  ☐ Initials

We ask your cooperation in keeping your appointments so that we may continue to provide quality care one patient at a time.

_____ _____

Patient or Parent/Guardian Signature **Date**