Mark A. Nobles, DMD **Willowbrook Dental Center** Ben W. Harrelson, DMD

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

DATE:_____

LAST NAME:_____ FIRST:_____ M.I.:_____

ADDRESS:_____ CITY:_____ STATE/ZIP:_____

HOME:_____ CELL:_____WK:_____

BIRTHDATE:_____ AGE:_____ MALE/ FEMALE MARRIED /SINGLE / DIVORCED /WIDOWED

SOCIAL SECURITY NO._____ EMPLOYER:_____

POSITION : _____ EMAIL ADDRESS:_____

SPOUSE:_____ SPOUSE CELL# _____

IF PATIENT IS A CHILD OR DEPENDANT:

MOTHER'S NAME:_____ DOB:_____ SOCIAL SECURITY NO._____

ADDRESS:_____ CITY:_____ STATE/ZIP:_____

EMPLOYER:_____ WK:_____ HOME:_____ CELL:_____

FATHER'S NAME:_____ DOB:_____ SOCIAL SECURYTY NO:_____

ADDRESS:_____ CITY:_____ STATE/ZIP:_____

EMPLOYER:_____ WK:_____ HOME:_____ CELL:_____

**** Please note the parent that brings the child/dependant to the appointment and signs this form is the responsible party.*****

DENTAL INSURANCE :

PRIMARY CARRIER:

INSURANCE:_____ GROUP:_____

EMPLOYER NAME:_____ WORK NUMBER:_____

INSURED'S NAME:_____ DATE OF BIRTH:_____

INSURED I/D #:_____ SOCIAL #:_____

SECONDARY CARRIER:

INSURANCE:_____ GROUP:_____

EMPLOYER NAME:_____ WORK NUMBER:_____

INSURED'S NAME:_____ DATE OF BIRTH:_____

INSURED I/D #:_____ SOCIAL #:_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutally agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. **Our office does not guarantee that your insurance will pay.** We make every attempt, at the beginning of your care to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. Any balance due, after your insurance will be billed promptly. Our software is designed for family accounts. If you do not want all family members on the same account it is the patient's responsibility to inform us at the initial appointment. **Please note we will only send a statement when a patient balance is due. A service fee of $8.00 will be added each month to your account for any additional statements mailed. Please note that any unpaid accounts will be forwarded to an outside agency for collection and any additional cost/fees incurred during the collection process with be the responsibility of the patient.** A fee of 30% will be added to the account balance at the time the account is forwarded to collection. If the percentage is under $35.00 a fee of $35.00 is automatically added before the account is forwarded.

I understand and agree the policies stated above:

_____

Signature of Patient or Guardian Date

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE?_____

NAME:_____ RELATIONSHIP:_____

PERSON TO CONTACT FOR EMERGENCY:

NAME:_____ CELL/HM #:_____

YOU WERE REFERRED TO US BY:_____

540 Willowbrook Road, Columbus, MS 39705 Tele:662-327-4523

Insurance Assignment Policy

All insurance companies recite a disclaimer upon verification of coverage… which states they will provide the information regarding coverage under your policy, but anything quoted is not a guarantee of payment. That can only be determined upon receipt of your claim.

Claims are billed from this office daily for the service provided. Insurance claims processing can take anywhere from 2 weeks to 5 weeks. This includes pre treatment request. The Mississippi quality insurance law states clean claims must be paid within 45 days. If we do not receive payment within that period of time, a tracer will be sent. If the insurance does not pay within 90 days then you will be responsible for the claim amount.

Patient cost share, deductible, percentages are based on the information received at the time of insurance verifications. Amounts collected from you are based on the information provided by your insurance company. These are estimates only, not an exact amount. Your insurance can not provide us with an exact guarantee of their payment and therefore we can only offer an estimate of your responsibility. This means that you may receive a statement after your insurance has processed your claim.

The patient is responsible to inform the office of any changes in their dental insurance prior to their dental treatment. This information should be presented at the time of check in.

_____ _____

Signature of Patient/Gaurdian Date

****

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign the Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____ _____

Signature Date

Communications Regarding My Accounts & Appointments

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts and appointments from any servicers and collections of my accounts, through various means such as 1.) any cell, landline, or text number that I provide. 2.) any email address that I provide. 3.) auto dialer systems. 4) voicemail messages and other forms of communications.

_____ _____

Responsible Party Signature Date

Willowbrook Dental Center, 540 Willowbrook Road, Columbus, MS 39705

DENTAL HISTORY

What is the reason for your visit today? _____

_____

How often do you have dental examinations?_____

How often do you brush your teeth_____ How often do you floss_____

Have you ever used or are currently using topical floride? YES NO

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? YES NO if yes, please describe _____

_____

Are any of your teeth sensitive to:

Hot cold?..... Yes No

Sweets?..... Yes No

Biting or Chewing?..... Yes No

Have you noticed any mouth odors or bad tastes..... Yes No

Do you frequently get cold sores, blisters or any other oral lesions..... Yes No

Do your gums bleed or hurt?..... Yes No

Have your parents experienced gum disease or tooth loss?..... Yes No

Have you noticed any loose teeth or change in your bite?..... Yes No

Does food tend to become caught in between your teeth?..... Yes No

If yes, where_____

Do you:

Clench or grind your teeth while awake or asleep?..... Yes No

Bite your lips or cheeks regularly?..... Yes No

Hold foreign objects with your teeth?..... Yes No

Mouth breathe while awake or asleep?..... Yes No

Have tired jaws, especially in the morning?..... Yes No

Snore or have any other sleeping disorders?..... Yes No

Smoke/chew tobacco or use other tobacco products?..... Yes No

Have you ever had:

Orthodontic Treatment?..... Yes No

Oral Surgery?..... Yes No

Periodontal Treatment?..... Yes No

Your teeth ground or the bite adjusted?..... Yes No

A bite plate or mouth guard?..... Yes No

A serious injury to the mouth or head?..... Yes No

Please describe, including cause_____

Have you experienced:

Clicking or popping of the jaw?..... Yes No

Pain?(joint, ear, side of face)..... Yes No

Difficulty in opening or closing the mouth?..... Yes No

Difficulty in chewing on either side of the mouth?..... Yes No

Headaches, neckaches or shoulder aches?..... Yes No

Sore muscles (neck, shoulders)?..... Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to replace your silver fillings?..... Yes No

Would you like to keep all of your teeth all of your life?..... Yes No

Do you feel nervous about having dental treatment?..... Yes No

Please describe_____

Have you ever had an upsetting dental experience?..... Yes No

Please describe_____

Have you ever been told to take a pre-medication prior to dental treatment?..... Yes No

Is there anything else about having dental treatment that you would like us to know?..... Yes No

If yes, please describe_____

_____

Medical History

1. Physicians's name _____ Phone ( ) _____
   Have you had and medical care within the past two years?..... Yes No
   Describe_____
2. Have you taken any medication or drugs during the past two years?..... Yes No
   If yes, please list name and dosage_____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosage of asprin?..... Yes No
   If yes, please list name and dosage_____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other disphosphonates?..... Yes No
   If yes, please list name and dosage_____
5. Are you aware of having an allergic (or adverse) reaction to any substance or medication?..... Yes No
   If yes, please specify _____
6. Have you been patient in the hospital during the past five years?..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)… Yes No	Ulcers…… Yes No	Hepatitis A B C (circle) ……. Yes No
Chest Pain…….. Yes No	Diabetes…….. Yes No	Venereal Disease……..... Yes No
Congenital Heart Disease…… Yes No	Thyroid Problems…….. Yes No	A.I.D.S./H.I.V. Positive…… Yes No
Heart Murmur…….. Yes No	Glaucoma……... Yes No	Cold Sores/Fever Blisters…… Yes No
High/Low Blood Pressure…… Yes No	Contact lenses…….. Yes No	Blood Transfusion…… Yes No
Mitral Valve Prolapse…… Yes No	Emphysema……... Yes No	Hemophilia…… Yes No
Artificial Heart Valve/Pacemaker…. Yes No	Chronis Cough…….. Yes No	Sickle Cell Disease…… Yes No
Rheumatic Fever…… Yes No	Tuberculosis…….. Yes No	Bruise Easily…… Yes No
Arthritis/Rheumatism…….. Yes No	Asthma…….. Yes No	Liver Disease/Yellow Jaundice….. Yes No
Cortisone Medicine…….. Yes No	Hay Fever/Allergy/Hives…….. Yes No	Neurological Disorders…… Yes No
Swollen Ankles…… Yes No	Latex Sensitivity……... Yes No	Epilepsy or Seizures…… Yes No
Stroke…… Yes No	Sinus Trouble…… Yes No	Fainting or Dizzy Spells…… Yes No
Diet (Special/Restricted)…… Yes No	Radiation Therapy…… Yes No	Nervous/Anxious…….. Yes No
Artificial Joints (hip, knee, etc.)……. Yes No	Chemotherapy……... Yes No	Psychiatric/Psychological care…... Yes No
Kidney Trouble…… Yes No	Tumors……... Yes No	Cancer…….. Yes No

8. Have you lost or gained more than 10 pounds in the past year?..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed?..... Yes No
   If yes, please list:_____
10. **Women:** Are you pregnant or think you could be pregnant? Yes ____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions?..... Yes No

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature_____ Date_____