PATIENT INFORMATION

Patient's Name _____ Preferred Name _____
First Middle Last

Date of Birth ____/____/____ Sex ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed

Address _____ Social Security Number ____/____/____
Number Street

City _____ State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work Email _____

Would you like appointment reminders by: ☐ phone ☐ text ☐ Email

Employer _____ Position _____

Who to contact in case of emergency _____ Phone Number (____) _____

Whom may we thank for referring you/How did you find out about us? _____
Please fill out

ACCOUNT INFORMATION

Who is financially responsible for this account? _____
First Middle Last

Relationship to patient? ☐ Self **(skip to Insurance Information)** ☐ Parent ☐ Child ☐ Spouse ☐ Other

Date of Birth ____/____/____ Sex ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed

Address _____ Social Security Number ____/____/____
Number Street

City _____ State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Employer _____
First Middle Last

Full Name of Dental Insurance Company _____

Employer ID Number/Contract Number _____ Group Number _____

Dental Insurance Company Address _____

Dental Insurance Company Phone Number ( ) _____ alt ( ) _____

If dental insurance is through the patient or financially responsible party, do not fill out the portion below.

Subscriber's relationship to patient? ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other

Date of Birth ____/____/____ Sex ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed

Address _____ Social Security Number ____/____/____
Number Street

City _____ State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

MEDICAL HISTORY

Your answers to the following questions are considered completely confidential. You may be asked questions about your responses to this questionnaire during your visit.

Are you under a physician's care now?	☐ Yes	☐ No	Explain: _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	Explain: _____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	Explain: _____
Are you taking any medications including non-prescription?	☐ Yes	☐ No	Explain: _____
Do you take a blood thinner or daily Aspirin?	☐ Yes	☐ No	Explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	Explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	Explain: _____
Are you on a special diet?	☐ Yes	☐ No	Explain: _____
Do you use tobacco?	☐ Yes	☐ No	Explain: _____
Do you use controlled substances?	☐ Yes	☐ No	Explain: _____

Women: ☐ Are you pregnant or trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal
☐ Latex	☐ Local Anesthetics	☐ Sulfa Drugs	☐ Other _____	

Do you have, or have you had, any of the following? Please circle or highlight all that apply.

AIDS/HIV Positive	Cold Sores/Fever Blisters	Hay Fever	Liver Disease	Sinus Trouble
Alzheimer's Disease	Congenital Heart Disorder	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Anaphylaxis	Convulsions	Heart Murmur	Lung Disease	Stomach/Intestine Disease
Anemia	Cortisone medicine	Heart Pace Maker	Mitral Valve Prolapse	Stroke
Angina	Diabetes	Heart Trouble/Disease	Osteoporosis	Swelling of Limbs
Arthritis/Gout	Drug Addiction	Hemophilia	Pain in Jaw Joints	Thyroid Disease
Artificial Heart Valve	Easily Winded	Hepatitis A	Parathyroid Disease	Tonsillitis
Artificial Bones/joints	Emphysema	Hepatitis B or C	Psychiatric Problems	Tuberculosis (TB)
Asthma	Epilepsy or Seizures	Herpes	Radiation Treatments	Tumors or Growths
Blood Disease	Excessive Bleeding	High Blood Pressure	Recent Weight Loss	Ulcers
Blood Transfusion	Excessive Thirst	High Cholesterol	Renal Disease	Venereal Disease
Breathing Problems	Fainting Spells/Dizziness	Hives or Rash	Rheumatic Fever	Yellow Jaundice
Bruise Easily	Frequent Cough	Hypoglycemia	Rheumatism	
Cancer/Tumor	Frequent Diarrhea	Irregular Heartbeat	Scarlet Fever	
Chemotherapy	Frequent Headaches	Kidney Problems	Shingles	
Chest Pains	Glaucoma	Leukemia	Sickle Cell Disease	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, explain

_____

Do you take or have you been told by a physician to take an antibiotic <u>Pre-Medication</u> 1 hour prior to dental treatment? ☐Yes ☐ No

I hereby consent to dental treatment at Nance Dental. I understand that my treatment options depend on my current health conditions. I am responsible for discussing any risks to my health with the staff at Nance Dental before my treatment begins.

Signature of Patient or Guardian _____ Date _____

NANCE DENTAL CLINIC
1952 MOUNT VERNON RD
TUPELO, MS 38804
662.842.6772

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* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____