PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial _____

Preferred Name: _____

RESPONSIBLE PARTY, IF SOMEONE OTHER THAN THE PATIENT (PARENT OR LEGAL GUARDIAN):

First Name: _____ Last Name: _____ Middle Initial _____

Address: _____ Apt., Suite, Lodge No. _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Driver's License: _____

Email Address: _____

PATIENT INFORMATION:

Address: _____ Apt., Suite, Lodge No. _____

City: _____ State _____ Zip Code: _____

Sex: _____ Male _____ Female

Marital Status: _____ Married _____ Single _____ Divorced _____ Separated _____ Widowed

Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Driver's License: _____

Email Address: _____ Preferred Pharmacy: _____

Mississippi Medicaid ID Number: _____ / For Private Insurance, Please See Next Page

Please list additional parents, legal guardians or others who may have access to patient records:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

_____

Signature of patient (or parent/legal guardian if a minor) Date

Patient Name: _____ Patient Birth Date: _____

PRIVATE INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Primary Insured: _____ Insured Birth Date: _____

Name of Employer: _____

Name of Insurance Company: _____ Insurance Co. Phone: _____

Group Number: _____ Member ID No.: _____

Patient Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other

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SECONDARY INSURANCE:

Name of Primary Insured: _____ Insured Birth Date: _____

Name of Employer: _____

Name of Insurance Company: _____ Insurance Co. Phone: _____

Group Number: _____ Member ID No.: _____

Patient Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other

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The biggest compliment our patients give us is the referral of their family and friends.

Who may we thank for referring you? _____

Are they a patient here? _____ Yes _____ No

If you were not referred to us by a family or friend, please share how you heard about us:

_____ Social Media: Facebook, Instagram, Twitter

_____ Our Website at treycombsdmd.com

_____ Insurance Company

_____ Building / Sign on Goodyear Boulevard

_____ Billboard on Telly Road

_____ Billboard at Betty K's restaurant

_____ Other: _____

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of the entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No

If yes, please provide details: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, please provide details: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If yes, please provide details: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

If yes, please provide details: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates (traditionally taken for Osteoporosis)? ☐ Yes ☐ No

If yes, please provide details: _____

Are you on a special diet? ☐ Yes ☐ No

If yes, please provide details: _____

Do you use tobacco? ☐ Yes ☐ No

Do you take a blood thinner? ☐ Yes ☐ No

Women, are you:

☐ Pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives

Are you allergic to any of the following:

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Red Dye	☐ Yellow Dye	☐ Other Dyes	

Do you use controlled substances? ☐ Yes ☐ No

If yes, please provide details: _____

Do you have any other allergies? ☐ Yes ☐ No

If yes, please provide details: _____

Do you have Food Allergies? ☐ Yes ☐ No

If yes, please provide details: _____

Patient Name: _____ Birth Date: _____

Please check the box if you have, or have ever had, any of the following?

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

Do you have, or have you ever had, any serious illness not listed above? ☐ Yes ☐ No

If yes, please provide details: _____

Additional Comments:

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: _____ Date: _____

Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

Crystal G. Combs, Business Administrator / Picayune General Dentistry, Inc.

500 Goodyear Boulevard, Picayune, MS 39466

(601) 798-0500 phone

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature:_____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by:_____ Date: ___/___/___

FINANCIAL & APPOINTMENT POLICY

FINANCIAL POLICY: PAYMENTS & INSURANCE

Payment is required at the time services are rendered including applicable deductibles, coinsurance, and co-payments. We accept cash, VISA, MasterCard, Discover and personal checks (there is a $40 service charge for returned checks). If you are unable to pay your co-pay at the time of service, your appointment will be rescheduled as this is a breach of our and your contract with the insurance company. Please do not expect to be seen if you are unable to meet your financial obligations.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. If it becomes necessary to forward your account to a collection agency or attorney for the purpose of collection, in addition to the amount owed, you will be responsible for any fees charged by the collection agency and/or attorney.

You are responsible for providing us with current and accurate insurance information. We will bill your insurance company for all services provided. You are expected to pay your deductible, coinsurance and co-payment at the time of service. We will estimate the amount you owe at the time of service based on the information we receive when verifying your insurance coverage; however, it is ultimately your responsibility to know your coverage. You are responsible for all charges not covered and/or paid by your insurance. If there is a conflict with your insurance regarding coverage, including primary or secondary insurance eligibility, it is your responsibility to resolve this conflict. If not resolved in the time frame allowed by your insurance company to submit claims, you may no longer be allowed to appoint in our office. If you need assistance or have questions regarding your insurance coverage or account balance, you may contact our office at (601) 798-0500.

APPOINTMENT POLICY: MISSED APPOINTMENTS, LATE ARRIVALS, LATE CANCELLATIONS & CONFIRMATIONS

Missed appointments represent a cost to us, and an inconvenience to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. If you have a series of appointments scheduled and fail to show up for any one of these appointments without calling to cancel or reschedule with proper notice, all remaining appointments will be cancelled for you and any family members that may also be scheduled.

A failed appointment occurs for any of the following reasons:

- The patient or patient's parent/legal guardian does not provide at least 24 hours notice of cancellation;
- The patient does not show up for a scheduled appointment; or
- The patient arrives more than 5 minutes after the scheduled time of the appointment, requiring the appointment to be rescheduled.

Excessive missed appointments or late cancellations may result in discharge from the practice for the patient and all family members. By signing this form, you understand that if you or any member of your family, individually or collectively, have three or more failed appointments that you may no longer be allowed to appoint in the future.

Our office confirms appointments on the business day prior to the scheduled appointment. It is your responsibility to maintain current contact information. *If we are unable to confirm an appointment that is scheduled more than 14 days in advance of the visit, we reserve the right to cancel the appointment without notice to the patient.*

I have read and understand this Financial and Appointment Policy.

_____	_____
Patient Name	Date
_____	_____
Patient or Parent/Legal Signature	Parent/Legal Guardian Name