Pearl River Dental
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Pearl, MS 39208
Telephone (601)-936-6161 **Fax** (601)-936-6163
www.pearlriverdentalgroup.com

PEARL RIVER DENTAL
Simply Sensational Smiles

WELCOME TO OUR PEARL RIVER DENTAL FAMILY!

We're so delighted that you've chose us as your home for your oral care needs! We look forward to getting to know you. Here are 3 things that you should know about us:

1. Pick appointment times that work around your schedule. We reserve the perfect amount of time to facilitate your treatment needs. In the event of a cancellation, we require 24 hour notice. Otherwise, your account will be subjected to a $40 cancellation fee.

2. At a convenience to you, all treatment plans will be reviewed in detail and co-pays collected before services are rendered so that there are no surprises.

3. You're always eligible for 10% off of services provided for the day if you share a friendly comment on our website or a Facebook post using the following hashtags #pearlriverdental #pearlywhites

Thank you again for choosing Pearl River Dental, we look forward to answering any questions that you may have. We're excited about our journey together. Sit back, relax and Smile!

Thank You,

Pearl River Dental

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Patient Information

Patient Name:_____ Preferred Name:_____

Birthdate:_____ Male:_____ Female:_____ Married:_____ Single:_____Minor: Y N

SS#:_____Driver's License #:_____

Address:_____City:_____State:_____ Zip:_____

Home #:_____ Work#:_____ Cell #:_____

E-Mail Address:_____

Employer:_____

Emergency Contact: _____ Phone #:_____

How did you hear of us? _____

If referred by someone, whom may we thank for the referral?_____

Parent/Guardian Information (If patient is a minor):

Name:_____ Relationship to patient:_____

Birth Date:_____ SS#:_____Driver's License #:_____

Address:_____ City:_____ State:_____ Zip:_____

Home#: _____ Work#: _____ Cell#: _____

**********************Office Payment Policy and Financial Agreement************************

All services will be paid at the time of the visit with the exception of deferred insurance balances. A balance unpaid for three (3) months will be considered delinquent and be turned over to a collection agency. A collection fee of 50% of the balance will be added to the cost being sent to collections. There is a $40.00 return check fee. You are responsible for ALL Collection Cost, Any Attorney Fees or Court Cost will also be the responsibility of the person financially responsible for the account.

SIGNED: _____DATE:_____

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Insurance Information

THE OFFICE CANNOT VERIFY BENEFITS WITHOUT ALL BLANKS COMPLPETETED
IT WILL BE RETURNED TO YOU FOR COMPLETION

POLICY HOLDER ONLY!!

Primary Dental Insurance: _____

Secondary Insurance:_____

*Name of Insured: _____ ID #: _____

SS#:_____ Date of Birth: _____

Employment of Insured: _____

Employment Address: _____

Zip Code:_____ Employer's Phone: _____

Group Name: _____ Group Number:_____

Claims Office Address: _____

City:_____ State:_____ Zip Code:_____

Provider Information Phone Number: _____

INSURANCE

As a courtesy to our patients, we will be happy to file your insurance relative to your treatment. Our professional services are rendered to you **NOT** the insurance company. **YOU** are directly responsible to us for the obligation of providing us with complete dental insurance information. We retain the right to refuse filing your dental insurance if the information is not provided and updated on a timely manner. Our office will **ESTIMATE** the percentage the insurance will pay and you will be responsible for the percentage not covered. These fees will be collected at the time serviced are rendered. **YOU WILL BE RESPOSIBLE FOR ALL CHARGES DEEMED INELIGIBLE OR DENIED BY THE INSURANCE COMPANY.** Only in this manner can we achieve the best interpersonal relationship and optimum treatment demanded.

Patient/Guardian Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship

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)

_____

_____

_____

DENTAL HISTORY

Please check any of the following problems that apply to you.	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Periodontal (gum) treatments	☐	☐

Please share the following dates:

- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐
How much?_____ For how long? _____		
If I could change my smile, I would:		
-Make it whiter	☐	☐
-Make it straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Angina (Chest pain)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Ulcers	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Venereal Diseases	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	Other _____		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐			
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐			
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐			
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐			

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐

Other _____

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

Family Physician Phone Number

_____

Consent:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent if child) **Date** **Dentist Signature**