Tracey Douglas, DMD
GENERAL DENTISTRY

204 Waterford Square
Madison, MS 39110
OFFICE: 601-856-9779
FAX: 601-856-9120

Welcome!

To help us get to know you and provide you with the best possible care please fill out this form completely. If you have any questions or concerns, please ask. We will be happy to assist you in any way. Please feel confident that the information contained in this form will be kept confidential.

GENERAL INFORMATION

Name _____ _____ Preferred _____
Address _____
City _____ State _____ Zip Code _____
Phone-Home _____ Work _____ Cell_____
Place of Employment: _____
SSN _____ Date of Birth _____
Marital Status ❑ Single ❑ Married ❑ Child
EMAIL ADDRESS _____
Spouse's or Parent's Name _____
SSN _____ Date of Birth _____
Emergency Contact _____ Phone _____
Whom May We Thank For Referring You? _____

If person listed above is not responsible for their account, please provide contact information for the responsible party below:
Name As It Appears On Insurance Card _____
Address _____
City _____ State _____ Zip Code _____
Phone-Home _____ Work Phone _____ Cell_____
Place of Employment _____
SSN _____ Date of Birth _____
DENTAL INSURANCE INFORMATION _____

Privacy Act Acknowledgement

I have received the Notice of Privacy Practices (HIPAA) and I have been provided an opportunity to review it.

Consent to Treatment

I hereby grant authority to Dr. Tracey Douglas, and/or the dentist in charge of my care, to administer such anesthetics; and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case.

Signed _____ Date _____

Medical History Information

Physician _____ Phone _____ Date of Last Exam _____

1. Are you under medical care now? ❑ Yes ❑ No

2. Have you been hospitalized for any reason within the last five years? ❑ Yes ❑ No
   If yes, please explain _____

3. Are you taking any medication(s) including non-prescription medicine? ❑ Yes ❑ No
   If yes, what medication(s) are you taking? _____

4. Have you ever taken pre-medication for dental treatment? ❑ Yes ❑ No
   Such as: Heart Murmur, Mitral Valve Prolapse, Artificial Joint Replacement

5. Do you use any of the following? Tobacco: ❑ Yes ❑ No
   Controlled substances: ❑ Yes ❑ No

PLEASE CIRCLE YES OR NO IN THE FOLLOWING SECTIONS

6. Do you or have you had any of the following? (Please circle)

High Blood Pressure	Yes	No	Fainting/Seizures	Yes	No
Heart Attack	Yes	No	Asthma	Yes	No
Heart Disease	Yes	No	Epilepsy	Yes	No
Cardiac Pacemaker	Yes	No	Leukemia	Yes	No
Rheumatic Fever	Yes	No	Diabetes	Yes	No
Heart Murmur	Yes	No	Kidney Diseases	Yes	No
Angina	Yes	No	AIDS/HIV Infection	Yes	No
Mitral Valve Prolapse	Yes	No	Thyroid Problems	Yes	No
Stroke	Yes	No	Cancer	Yes	No
Emphysema	Yes	No	Hepatitis/Jaundice	Yes	No
Respiratory Problems	Yes	No	Liver Disease	Yes	No

7. Are you allergic to or have you had any reactions to the following? (Please circle)

Local Anesthetics	Yes	No
Penicillin/Antibiotics	Yes	No
Barbiturates	Yes	No
Aspirin	Yes	No
Sedatives	Yes	No
Codeine	Yes	No
Hydrocodone	Yes	No
Latex	Yes	No
Sulfa Drugs	Yes	No
Iodine	Yes	No
Any Metals	Yes	No
Other	Yes	No

8. Women Only:

Are you pregnant or think you may be pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking oral contraceptives?	Yes	No

Dental History (Please circle)

1. Do your gums bleed while brushing or flossing?	Yes	No
2. Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
3. Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
4. Do you feel any pain in any of your teeth?	Yes	No
5. Do you have lumps or sores in or near your mouth?	Yes	No
6. Have you ever had any head, neck or jaw injury?	Yes	No
7. Have you ever experienced any pain or discomfort? associated with your TMJ area (upper jaw area)?	Yes	No
8. Do you have frequent headaches?	Yes	No
9. Do you clench or grind your teeth?	Yes	No
10. Have you ever had difficult extractions in the past?	Yes	No
11. Do you like your smile?	Yes	No
12. Have you received orthodontic treatment before?	Yes	No

Authorization and Release

I certify that I have read and understand the above to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be detrimental to my health. I authorize the dentist to release my information including the 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 payment of all services rendered on my behalf or my dependents.

Signature of Patient or Responsible Party _____

FINANCIAL ARRANGEMENTS, DENTAL INSURANCE AND OFFICE POLICY

We are committed to providing you with our best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, or Visa. There is also outside financing available, please ask for additional information. Except on initial visits, you are responsible for the percentages that insurance will not cover. On initial visits, unless we can verify your coverage, you are responsible for the full fee at the time of service.

Returned checks will be charged a $30.00 NSF fee and outstanding balances older than 30 days will be charged interest at a monthly rate of 1.50%. If you should have an outstanding balance, you will receive a monthly statement from us and payment should be directed to the address on the remittance statement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. This is to notify those utilizing insurance for payment that if the balance of the account is not paid within 30 days, you will be notified that your insurance company has not paid and we will require payment directly from you.
3. We will file the insurance payment as a courtesy, but it is not our responsibility to make certain whether or not they pay. This is your responsibility.
4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a dental care provider, our relationship is with you, not the insurance company. While filing of the insurance claim is a courtesy to you, all charges are your responsibility from the date services are rendered.

If you have any questions about the information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help you.

Signature _____ Date _____