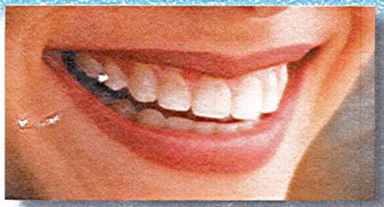


Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ____________
SS#/SIN ____________
Date ____________
Patient's Sex ☐ F ☐ M

Patient Information (CONFIDENTIAL)

Name ____________ Birthdate ____________ Home Phone ____________
Address ____________ City ____________ State/Prov. ______ Zip/P.C. ______
Email ____________ Cell Phone ____________
Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College ____________ City ____________ State/Prov. ______ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer ____________ Work Phone ____________
Business Address ____________ City ____________ State/Prov. ______ Zip/P.C. ______
Spouse or Parent/Guardian's Name ____________ Employer ____________ Work Phone ____________
Whom may we thank for referring you? ____________
Person to contact in case of emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________
Address ____________ Home Phone ____________
Email ____________ Cell Phone ____________
Driver's License# ____________ Birthdate ____________ Financial Institution ____________
Employer ____________ Work Phone ____________ SS#/SIN ____________
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

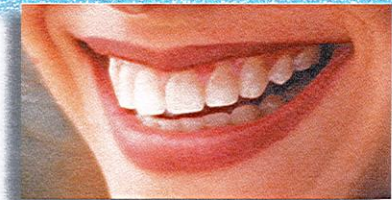
Insurance Information

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS#/SIN ____________ Date Employed ____________
Name of Employer ____________ Union or Local # ____________ Work Phone ____________
Address of Employer ____________ City ____________ State/Prov. ______ Zip/P.C. ______
Insurance Company ____________ Group # ____________ Policy/ID # ____________
Ins. Co. Address ____________ City ____________ State/Prov. ______ Zip/P.C. ______
How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ____________ Relationship to Patient ____________
Birthdate ____________ SS#/SIN ____________ Date Employed ____________
Name of Employer ____________ Union or Local # ____________ Work Phone ____________
Address of Employer ____________ City ____________ State/Prov. ______ Zip/P.C. ______
Insurance Company ____________ Group # ____________ Policy/ID # ____________
Ins. Co. Address ____________ City ____________ State/Prov. ______ Zip/P.C. ______
How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

Over Please



Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________________		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ____________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

Payment is due in full at the time of treatment *unless prior arrangements have been approved.*

This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X ____ ______________

Signature of patient (or parent/guardian if Date

CONSENT FOR TREATMENT

1. I hereby authorize Clinton Dental Care or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed necessary by doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually 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 risks. I understand that I can ask for complete recital of any complications.
4. I understand that during the course of the procedure(s) unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore consent to the performance of additional procedures which Dr. Grubbs may consider necessary. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s).
5. Lastly, I agree to be responsible for payment of all services rendered on my behalf and my dependents. I understand that payment is due at time of service unless other arrangements have been made prior to service(s).

Patient: ____

Date: ____

Responsible Party: _________________________________

Relationship to Patient: ______________________________

CLINTON DENTAL CARE OFFICE AND FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy.

Payment is due at the time service is provided. We accept cash, personal checks, cashier's checks, money orders, Visa, Mastercard, Discover, and Care Credit. Returned checks will be subject to additional fees. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer, and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process. If my account is turned over to the collection agency, I will be responsible for all collection/legal fees.

I understand, all services are billed the day a procedure is started and I am responsible for fees charged. I understand it is my responsibility to keep follow up appointments for those procedures that require more than one visit.

Separated & Divorced Couples with Dependent Children: It is the policy of this office to bill the parent that brings the children in for their dental treatment. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

All patients must provide an ID Card & Insurance Card (if applicable) to be copied at the time of appointment. **SOCIAL SECURITY NUMBER** is needed to file insurance claims. We also require home and work telephone numbers, as well as a contact number to use in case of emergency.

Cancellation & Late Policy: Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very strict schedule and must insist that appointment times be respected. For cancellation we require 24 hours advanced notice, if notice is not given, you will be charged a $50.00 fee at our discretion. An answer machine is available for messages left after business hours. Three missed appointments may result in dismissal as a patient.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. *Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.*

CONSENT: I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. The undersigned hereby 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 understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I authorize Clinton Dental Care to contact me by phone, text, email, or any other method deemed necessary. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Signature: ______________________________

Date: ______________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability& Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

M. Clayton Grubbs, DMD

AUTHORIZATION FOR USE OF PATIENT PHOTOGRAPHIC AND/OR VIDEO IMAGES

AUTHORIZATION:

I authorize the use and disclosure of name, photographic/video images and/or testimonial for marketing purposes by the practice listed above. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPAA privacy regulations.

PURPOSE:

The photographic/video images and/or testimonial will be used for Social Media and/or Advertising.

REVOCABILITY:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from the date signed.

NO TREATMENT CONDITIONS:

I understand that the practice cannot condition treatment on whether or not I sign the authorization.

☐ I confirm and agree.

____ ________________

Patient or legal guardian signature Date

736 Clinton Parkway, Clinton MS 39056