6 Medical Park Dr.
Fulton, MS 38843
(662) 862-7434
www.marquisdentalcenter.com

1013 W. Jackson St.
Tupelo, MS 38804
(662) 823-7900
www.renewdentaltupelo.com

PATIENT INFORMATION

☐ MARRIED ☐ SINGLE ☐ MINOR ☐ STUDENT ☐ MALE ☐ FEMALE

NAME: ____
Last First MI PREFERRED NAME

ADDRESS: ____
Street APT # City State Zip

BIRTHDATE: ____________________ AGE: ________ SS#: ____________________

HOME PHONE: ________________ CELL: ________________ EMAIL: ____________________

PLACE OF EMPLOYMENT:______________________________ WORK PHONE: ________________

EMERGENCY CONTACT/RELATIONSHIP:______________________________ PHONE: ________________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another Patient ☐ Another Dental/Doctor Office
☐ Yellow Pages ☐ Facebook ☐ Google ☐ School ☐ Work ☐ Other ____________________

Name of person or office referring you to our practice: ______________________________

FINANCIAL RESPONSIBLE PARTY (if under 21, MUST be parent or legal guardian)

NAME: ______________________________ RELATIONSHIP TO PATIENT: ________________
Last First MI

ADDRESS: ____
Street APT # City State Zip

BIRTHDATE: ____________________ AGE: ________ SS#: ____________________

HOME PHONE: ________________ CELL: ________________ EMAIL: ____________________

PLACE OF EMPLOYMENT:______________________________PHONE: ________________

AUTHORIZATION (ALL Patients or Legal Guardians MUST Sign)

I authorize Marquis Dental Center/Renew Dental to perform diagnostic procedures and treatment as they may be necessary for proper dental care. I authorize release of any information concerning mine or my child's health care, advice and treatment provided for the purpose of evaluating and administering claim for insurance benefits or credit information. I authorize payment of insurance benefits directly to Marquis Dental Center/Renew Dental, otherwise payable to me. I understand that all insurance co- pay estimates are due the day of service. I understand that I am responsible for all charges on this account. If no insurance, I understand that all charges are to be paid at the time services are rendered unless prior arrangements have been made. I authorize all insurance payments to be paid directly to Marquis Dental Center/Renew Dental. I understand that if the insurance payment is sent to me, it is my responsibility to forward payment on to Marquis Dental Center**. All balances are due within 30 days.** If payment in full or payment arrangements are not made, I understand that my account could go to an outside collection agency on any account over 90 days old. **Finance charges will incur on any account over 60 days old in the amount of 12% annually (1% monthly). If turned over for collections, I understand that my account will be assessed collection and attorney fees in the amount of up to 45%. I understand that my account will be charged a $40 fee for any returned check due to NSF funds or closed accounts.**

PATIENT OR LEGAL GUARDIAN______________________________ DATE ________________

MEDICAL HISTORY

NAME OF PRIMARY CARE PHYSICIAN? ______________________________

Have you ever been hospitalized or had a major operation? **YES** **NO**

EXPLAIN: ______________________________

Are you ALLERGIC to any medications or substances? **YES** **NO**

Please list if not listed below: ______________________________

- ☐ **Aspirin**
- ☐ **Penicillin**
- ☐ **Codeine**
- ☐ **Acrylic**
- ☐ **Metal**
- ☐ **Latex Rubber**
- ☐ **Other**

WOMEN: ☐ **Pregnant/Trying to Get Pregnant** ☐ **Nursing** ☐ **Taking Oral Contraceptives**

****If you answered yes to any of the starred questions, please call prior to your appointment.PREMEDICATION may be required****

	YES	NO		YES	NO		YES	NO
Heart Disease	☐	☐	Diabetes	☐	☐	AIDS/HIV Positive	☐	☐
Heart Murmur*	☐	☐	Cold Sores	☐	☐	Hypoglycemia	☐	☐
Drug Addiction	☐	☐	Angina/Chest Pains	☐	☐	Lung Disease	☐	☐
Liver Disease	☐	☐	Heart Attack/Failure	☐	☐	Breathing Problems	☐	☐
Hepatitis A/B/C	☐	☐	Herpes	☐	☐	Mitral Valve Prolapse*	☐	☐
Stroke	☐	☐	Scarlet Fever	☐	☐	Hay Fever	☐	☐
Convulsions	☐	☐	Rheumatic Fever*	☐	☐	Artificial Heart Valve*	☐	☐
Sinus Trouble	☐	☐	Kidney Problems	☐	☐	Renal Dialysis	☐	☐
Epilepsy/Seizures	☐	☐	Pacemaker	☐	☐	Heart Surgery*	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Stomach Disease	☐	☐
Ulcers	☐	☐	Glaucoma	☐	☐	Alzheimer’s Disease	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Thyroid	☐	☐
Pain in Jaw Joint	☐	☐	Artificial Joints*	☐	☐	Tumors/Growths	☐	☐
Allergies (Pollen/Dust)	☐	☐	Cancer	☐	☐	Chemotherapy	☐	☐
Steroid Therapy	☐	☐	Organ Transplant*	☐	☐	Nervousness	☐	☐
Asthma	☐	☐	Radiation	☐	☐	Arthritis/Gout	☐	☐
Rheumatism	☐	☐	Psychiatric Care	☐	☐	Fainting/Dizziness	☐	☐
Excessive Bleeding	☐	☐	Sleep Apnea	☐	☐	Other ☐	☐	

Have you ever had any illnesses not checked above? YES NO

EXPLAIN: ____

List of Medications: ____

Do you smoke? YES _____ NO _____ How many packs per day? ____________

Do you use any other form of tobacco? YES _____ NO _____ What kind? _______________________

Number of sodas or sweet drinks per day? _____________

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform Marquis Dental Center/Renew Dental.

PATIENT OR LEGAL GUARDIAN (IF PATIENT IS UNDER 21) SIGNATURE_________________________ DATE__________

DENTAL HISTORY

Name of previous dentist: ____

Date of last dental visit: ____

How long since last cleaning? ____

Reason for changing dentist: ____

Describe your current dental problem: ____

APPREHENSION

Do you experience fear of having dental treatment performed? YES NO

Have you had an unpleasant dental experience? YES NO

Do you dread the numbing after effects? YES NO

Do you feel you need any help overcoming fear? YES NO

TEETH PROBLEMS

Are your teeth sensitive to hot, cold, sweets or pressure? YES NO

Does food wedge between certain teeth? YES NO

Do you have areas that are hard to floss? YES NO

GUM PROBLEMS

Do your gums ever bleed when you brush or floss? YES NO

Have your gums receded from your teeth? YES NO

Do you have bad breath or a bad taste in your mouth? YES NO

HEADACHES/FACIAL PAIN

Do you have frequent headaches? YES NO

Do you experience popping or clicking upon opening or closing? YES NO

Do you experience facial muscle pain while chewing or when you wake up? YES NO

YOUR SMILE

Do you think you have a pretty smile? YES NO

Are your teeth crooked? YES NO

If so, does this bother you? YES NO

Have you had any cosmetic dentistry? YES NO

Would you like to have whiter teeth? YES NO

Do you have any fillings or blemishes on your teeth that make them look bad? YES NO

PLEASE LIST ANY CONCERNS THAT YOU WOULD LIKE TO DISCUSS:_____________________________

____

X____ ______________________

Patient Signature (Legal Guardian if under 21) **Date**

PATIENTS NAME:______________________________________DATE OF BIRTH: _______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I,____, do hereby give my permission for Marquis Dental Center/Renew Dental to discuss any and all medical/dental records and/or bring my child **(if under 21)** for dental care/treatment with the following physician/person in regards to myself or my child **(if under 21):**

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

***** PLEASE NOTE THAT IF A PERSON IS NOT LISTED ON THIS FORM THAT WE WILL NOT BE ABLE TO DISCUSS ANYTHING ABOUT YOU OR YOUR CHILD. ALSO, IF A CHILD IS A MINOR, ANY PERSON THAT WILL BE BRINGING YOUR CHILD TO THE DENTIST MUST ALSO BE LISTED. IF SOMEONE BRINGS YOUR CHILD AND THEY ARE NOT LISTED, WE WILL NOT BE ABLE TO SEE THEM AND THEY WILL HAVE TO BE RESCHEDULED. IT IS YOUR RESPONSIBILITY TO KEEP THIS LIST UPDATED AS NEEDED. *****

____

INITIALS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,____, have received a copy of Marquis Dental Center/Renew Dental Notice of Privacy Practices.

x____ ______________________________

Signature of Patient or Legal Guardian (if under 21) **DATE**