



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	PREFERRED NAME	
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 claims 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	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery*	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Jaw Joint	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints*	<input type="checkbox"/>	<input type="checkbox"/>	Tumors/Growths	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Steroid Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant*	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	
						<input type="checkbox"/>		

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
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Do you experience popping or clicking upon opening or closing?	YES	N O
Do you experience facial muscle pain while chewing or when you wake up?	YES	N O
YOUR SMILE		
Do you think you have a pretty smile?	YES	N O
Are your teeth crooked?	YES	N O
If so, does this bother you?	YES	N O
Have you had any cosmetic dentistry?	YES	NO
Would you like to have whiter teeth?	YES	N O
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