DULANEY DENTAL, PLLC
310 BYRAM PLACE, SUITE C
BYRAM, MS 39272

PATIENT INFORMATION SHEET

Name_____

Birth Date_____ Patient's Social Security #_____

Mailing Address_____

City_____ State_____ Zip Code_____

Home Ph._____ Work Ph._____ Cell Ph._____

Sex: Male ___ Female ___ Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed___

***For appointment reminders:
Preference – Email_____ or Text_____
Email Address _____ Cell Ph._____

Person Responsible for Account_____
Relationship _____ Work Ph._____ Cell Ph._____

Primary Dental Insurance Info:
Insured/Subscriber's Name_____
Insurance Co._____ Employer_____
Insured's Social Security#_____ Birth Date_____

Secondary Dental Insurance Info:
Insured/Subscriber's Name_____
Insurance Co._____ Employer_____
Insured's Social Security #_____ Birth Date_____

Whom can we thank for referring you to our office? _____

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DENTAL – MEDICAL HISTORY

Reason for today's appointment_____

Are you in good health? _____Are you pregnant? _____If so, due date_____

Your physician_____Your last visit_____

Are you under the care of a physician now?_____If yes, please explain_____

List any drug allergies or reactions_____

List medications you are taking now_____

Medical History:
Do you have a history of the following conditions? (Please check the ones that apply)

Heart Condition_____ High Blood Pressure_____ Diabetes_____ Allergies_____

Rheumatic Heart_____ Ulcers_____ Asthma_____ A.I.D.S._____

Tuberculosis_____ Thyroid Condition_____ Hepatitis_____ Epilepsy_____

Hip Replacement_____ Nervous Disorder_____ Free Bleeder_____ Dizziness_____

Knee Replacement_____ Popping in ears_____ Headaches_____ Facial pain_____

Other – please explain_____

Dental History:
Bleeding gums_____ Perio (gum) treatment_____ TMJ pain_____ Missing teeth_____

Allergy to latex_____ Sensitive teeth_____

Other – please explain_____

Last Dental Visit_____Reason for visit_____

Any unfavorable reaction?_____If yes, please explain_____

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FINANCIAL AGREEMENT

I certify that if I am covered by dental insurance, I assign directly to Dulaney Dental all insurance benefits, otherwise payable to me. I authorize the dentist to release any information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I understand that I am ultimately responsible for all charges, whether or not paid by insurance. I understand and agree that should this account be referred to an attorney or collection agency for recovery of any monies owed, I will be responsible for all collection fees (late fees, agency fees, attorney fees, court costs, etc) necessary to enforce collection. In addition, this agreement can be governed by, and construed in accordance with the laws of the state where the assigned collection agency and/or attorney is located, exclusive of choice of law rules. The parties each hereby consent to the jurisdiction and venue and waive any objections to such jurisdiction and venue.

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less that 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with **less than 24 hours** notification may be subject to a **$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel will be considered as **NO SHOW**. The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. For any questions, please call 601-373-1351.

Dulaney Dental, PLLC

Signature_____ **Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
Signature

_____
Date

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)

_____

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