Stubblefield Dental Clinic

508 Azalea Drive
Post Office Box 964
Oxford, MS. 38655
Phone: (662) 236-5858

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: SS # Prev. Visit

Email Address: Best time to call:

Phone: Home Work Ext Mobile

Address:

City State Zip Code

Employment

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code

I prefer to be contacted by: ☐ Cell ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

In an emergency, who should be notified? Please enter name, phone number, and relationship below:

Stubblefield Dental Clinic

Insurance Subscriber and/or Parent/Guardian Information

This page ONLY needs to be filled out if the insurance subscriber is OTHER than the patient AND/OR you are the parent/guardian of the patient

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS # _____ Driver's License # _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Stubblefield Dental Clinic

Primary Dental Insurance

Name of Insured: Last | First | MI | Preferred

Insured's Birth Date: | ID # | Group #

Insured's Address:

City | State | Zip Code

Insured's Employer Name:

Employer's Address:

City | State | Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City | State | Zip Code

Insurance Authorization

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

_____
Signature

Do you have secondary dental insurance?

◯ Yes ◯ No

Stubblefield Dental Clinic

Patient Name: Last | First | MI | Preferred

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Allergies
- ☐ *High Blood Pressure
- ☐ Allergy-Codeine
- ☐ Alzheimer's/Dementia
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Dizziness/Fainting
- ☐ Gastric/Acid Reflux
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Other
- ☐ Respiratory Problems
- ☐ STD/HPV
- ☐ *Diabetes
- ☐ *MVP
- ☐ Allergy-Latex
- ☐ Anemia
- ☐ Asthma/COPD
- ☐ Blood Thinners
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Head/Neck Injuries
- ☐ Hepatitis A/B/C
- ☐ Kidney Disease
- ☐ Nervous Disorders
- ☐ Pacemaker/Stents
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ *Heart Murmur
- ☐ *Rheumatic Fever
- ☐ Allergy-Penicillin
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Growths/Tumors
- ☐ Heart Attack/Stroke
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Radiation/Chemo
- ☐ Sinus
- ☐ Ulcers

- ☐ Pregnant/Planning Pregnancy/Nursing
- ☐ No Medical Conditions
- ☐ No Health Changes
- ☐ Headaches/Migraines
- ☐ Taking No Medications

Please clarify the conditions or alerts selected above including due date if pregnant:

Stubblefield Dental Clinic

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Describe any current medical treatment, recent hospitalizations or recent or impending surgery(s):

Name of physician and date of last physical exam

Name and phone number of preferred pharmacy

List all medications (prescription and non-prescription), including regular dosages of aspirin.

Please list any allergies and/or allergies to medications.

☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of x-rays and oral examinations. This will serve as my electronic signature.

Name of Patient/Parent or Guardian completing this form

Response Date:

Stubblefield Dental Clinic

Dental Information

How would you rate the condition of your mouth?

○ Excellent ○ Good ○ Fair ○ Poor

Previous Dentist Name and Phone Number

Approximate date of most recent dental exam and/or dental x-rays

I routinely see a dentist every

○ 3 mos ○ 4mos ○ 6 mos ○ 12mos ○ Not routinely

What is your immediate concern about your dental health?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/Have braces or orthodontic treatment
- ☐ Experience dry mouth
- ☐ Sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Whitened or bleached your teeth
- ☐ Experienced popping and/or clicking of your jaw joint
- ☐ Difficulty chewing
- ☐ Clenching or grinding of teeth
- ☐ Currently or previously wore a bite appliance
- ☐ Wears removable partial/denture
- ☐ Gums bleed when brushing or flossing
- ☐ Diagnosed and/or treated for gum disease

Stubblefield Dental Clinic

- ☐ Bone loss around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ Snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Stubblefield Dental Clinic

Privacy is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Stubblefield Dental Clinic. I hereby authorize, as indicated by my signature below, Stubblefield Dental Clinic to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile telephone number _____
- ☐ You may contact me on my work telephone number _____
- ☐ You can send me an email at: _____
- ☐ Other: _____

Please list authorized person with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____Relationship:_____Date_____(circle): added / removed
2. _____Relationship:_____Date_____(circle): added / removed
3. _____Relationship:_____Date_____(circle): added / removed
4. _____Relationship:_____Date_____(circle): added / removed

Stubblefield Dental Clinic

PATIENT CONSENT FOR SERVICES AND FINANCIAL POLICY

I authorize Stubblefield Dental Clinic, to perform all recommended treatment. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals. I authorized the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be paid in full before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Insurance: I authorize the Practice to release to staff, hospitals, healthcare service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that a NSF fee of $100 will be added to my account for any returned check.

I understand that any fee estimate for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assigned, to telephone me to discuss this statement or my treatment.

Please Initial_____

Stubblefield Dental Clinic

HIPPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revolved, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Cancellation Policy

We appreciate you and your family coming to our office. We strive very hard to give the BEST dental treatment available. To ensure that each patient receives adequate treatment, it is important that or office has current phone numbers and addresses at all times. It is necessary that we confirm all appointments.

Our office calls 1-2 days before to confirm. In the event that we cannot contact you due to invalid phone numbers, we reserve the right to cancel your appointment. If you need to reschedule or cancel an appointment, please give us a 24 hour notice on all cleanings and dental treatment appointments.

You may leave a message 24 hours a day at (662) 236-5858**. If you miss an appointment without notifying our office, we reserve the right to charge a missed appointment fee of $50.** All fees have to be paid to reschedule another appointment. Thank you for understanding.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____Date: _____

Patient's Address: _____

If patient is a child, please provide the parental or legal guardian's consent:

Signature: _____Relationship:_____Date:_____

Stubblefield Dental Clinic

NOTE(MINORS): The parent or legal guardian must complete this form for a minor (under age of 18), provide consent for dental treatment and accompany the child during each dental visit. If the parent or legal guardian consented to treatment in advance, an authorized individual named on Page may bring the child. Treatment will not be provided for unattended children.