NEW PATIENT INFORMATION FORM

Name _____ Date _____
First Middle Last Preferred Name

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone # _____ Work # _____

Email _____ Soc. Security # _____ Birthdate _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Email Address _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State. _____ Zip _____

X_____ _____
Signature of patient (or parent, if minor) **Date**

MEDICAL HISTORY

Name _____Physician Name_____Date of Last Visit _____

How would you rate your health? (Please circle) Good Fair Poor

Please circle:

Yes No Are you taking any medication? List: _____

Yes No Are you allergic to any medication? List:_____

Yes No Are you or have you taken medication for osteoporosis? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you ever had surgery or been hospitalized? _____

Yes No Do you use any form of tobacco? _____

Yes No Do you have any allergies? (medications, materials, etc?)_____

Do you have or have you ever had any of the following conditions?

Yes / No Abnormal Bleeding	Yes / No Hemophilia	Yes / No Thyroid Problems
Yes / No Alcohol Abuse	Yes / No Heart Problems	Yes / No Tuberculosis
Yes / No Anemia	Yes / No Heart Surgery	Yes / No Ulcers
Yes / No Angina Pectoris	Yes / No Hepatitis A, B, or C (circle type)	
Yes / No Arthritis	Yes / No High Blood Pressure	
Yes / No Artificial Heart Valve	Yes / No Joint Replacement	
Yes / No Asthma	Yes / No Kidney Disease	
Yes / No Blood Transfusion	Yes / No Liver Disease	
Yes / No Cancer	Yes / No Low Blood Pressure	
Yes / No Chemotherapy	Yes / No Mitral Valve Prolapse	
Yes / No Colitis	Yes / No Pacemaker	
Yes / No Congenital Heart Defect	Yes / No Psychiatric Problems	
Yes / No Diabetes	Yes / No Radiation Therapy	
Yes / No Drug Abuse	Yes / No Rheumatic Fever	
Yes / No Emphysema	Yes / No Seizures	
Yes / No Epilepsy	Yes / No Sexually Transmitted Disease	
Yes / No Fainting Spells	Yes / No Shingles	
Yes / No Fever Blisters	Yes / No Sickle Cell Disease	
Yes / No Glaucoma	Yes / No Sinus Problems	
Yes / No HIV or AIDS	Yes / No Stroke	

Females only, please answer:

Yes / No Are you pregnant? If so, how many weeks? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

DENTAL HISTORY

How may we help you today? _____

How would you rate your dental health? (Please circle) Good Fair Poor

Yes / No Do you require antibiotics before dental treatment?

Yes / No Are you in pain?

Yes / No Are your teeth sensitive to hot, cold, or anything else?

Yes / No Have you ever had any gum treatment?

Yes / No Do your gums bleed?

Yes / No Do you have any pain or discomfort in your jaw joint (TMJ)?

Yes / No Do you like the appearance of your teeth/smile?

Yes / No Are you happy with the color of your teeth?

Yes / No Are your teeth straight?

Yes / No Is there anything you would like to change about your smile? _____

How can we accommodate you better during your dental visit?

_____

_____

Please circle any services below that you would like to discuss during your visit:

Whitening	Bridges	Crowns	Veneers
Night Guards	Partials/Dentures	Sealants	Other

PATIENT PRIVACY CONSENT FORM:

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 health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and dental certifications

I have been informed by you of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 to obtain a current copy of the Notice of Privacy 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 agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____ Relationship to patient: _____

Signature: _____ Date: _____

FINANCIAL AGREEMENT:

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

_____
Signature

CANCELLATION POLICY:

We appreciate you and your family coming to our office. We strive very hard to give you the **best** dental treatment available.

To ensure that each patient receives adequate treatment, it is important that our 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 24 hour notice on all cleanings and dental treatment appointments. You may leave a message 24 hours a day at (662) 513-0055.

If you miss an appointment without notifying our office, we reserve the right to charge a missed appointment fee of $50.00. All fees have to be paid to reschedule another appointment.
Thank you for understanding.

_____
Signature

COMMUNICATION CONSENT:

Lee Dentistry utilizes an electronic confirmation and billing system. I welcome text and e-mail communications.

_____
Signature

PHOTOGRAPHIC RELEASE & CONSENT

I hereby grant Lee Family Dentistry and its representatives the irrevocable and unrestricted right to reproduce and display photographs of me in print, on the website, or any other lawful purpose for advertising. I release Lee Family Dentistry and its employees and legal representatives from any and all claims, actions and liability related to its use of said photographs.

The following exclusions may apply: _____

Printed name:_____

Signature:_____

Date:_____

MINORS ONLY:
If signature above is by a person under the age of 18, parent or guardian should sign below:

I, _____, the parent or guardian, hereby consent to the foregoing.

Parent/guardian signature:_____

Date:_____