



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 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.

X \_\_\_\_\_

PATIENT OR LEGAL GUARDIAN (IF PATIENT IS UNDER 21) SIGNATURE
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

LIST OF MEDICATIONS: \_\_\_\_\_

\*\*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: \_\_\_\_\_

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.

X \_\_\_\_\_

**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: \_\_\_\_\_

**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)**:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

X \_\_\_\_\_  
**Signature of Patient or Legal Guardian (if under 21)** **Date**

**PHOTOGRAPH RELEASE**

I, \_\_\_\_\_, hereby authorize Marquis Dental Center/Renew Dental to take photographs, slides, and/or video of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television, billboards, etc) and professional publications (dental magazines and journals). I do not expect compensation, financial or otherwise, for the use of the photographs, slides, or videos.

X \_\_\_\_\_  
**Signature of Patient or Legal Guardian (if under 21)** **Date**

**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**



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**MISSED APPOINTMENT POLICY**

Once a patient has missed two or more appointments, the patient will be placed on a short call list. This means you will not have a scheduled appointment but rather will be called when an appointment becomes available.

I, \_\_\_\_\_, have read and agree to Marquis Dental Center/Renew Dental missed appointment policy.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
**Signature of Patient or Legal Guardian (if under 21)** **Date**