MainStreet
FAMILY DENTISTRY

WELCOME! * * * * * * * * *

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Patient Number _____ Name _____
(Last / First / Initial)

Phone _____ Social Security Number _____ Date of Birth _____

Address _____

City _____ State _____ ZIP Code _____

Sex ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employer _____ Occupation _____ Business Phone _____

Employer Address _____
(Street / City / State / ZIP Code)

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us or whom may we thank for referring you? _____

PRIMARY INSURANCE

Person Responsible for Account _____ Relationship _____
(Last / First / Initial)

Phone _____ Social Security Number _____ Date of Birth _____

Address (if different) _____
(Street / City / State / ZIP Code)

Employer _____ Occupation _____ Business Phone _____

Employer Address _____
(Street / City / State / ZIP Code)

Insurance Company _____

Policy Number _____ Group Number _____ Subscriber Number _____

Names of Other Dependents _____

SECONDARY INSURANCE

Person Responsible for Account _____ Relationship _____
(Last / First / Initial)

Phone _____ Social Security Number _____ Date of Birth _____

Address (if different) _____
(Street / City / State / ZIP Code)

Employer _____ Occupation _____ Business Phone _____

Employer Address _____
(Street / City / State / ZIP Code)

Insurance Company _____

Policy Number _____ Group Number _____ Subscriber Number _____

Names of Other Dependents _____

* * * PLEASE COMPLETE BOTH SIDES. * * *

DENTAL HISTORY

Reason for Today's Visit _____ Date of Last Dental Care _____

Former Dentist _____ Date of Last Dental X-Rays _____

Address _____

Street City State ZIP Code

Place a check mark in the box if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-pen?" These include combinations of Ionamin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ■ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ■ No If yes, give approximate dates _____

Are you pregnant? ☐ Yes ■ No Nursing? ■ Yes ☐ No On birth control? ■ Yes ☐ No

Place a check mark in the box if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking _____

_____

_____

Allergies _____

_____

_____

AUTHORIZATION

I authorize my insurance company to pay to Main Street Family Dentistry, P.A. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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 _____ Date _____

* * * PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. * * *

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COMPLAINTS

Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

This notice is effective as of 10/01/2007.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print) _____

Patient's Signature _____ Date _____

Authorized Facility Signature _____ Date _____

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OUR FINANCIAL POLICY

Non-insured patients are expected to pay in full with cash, check or credit card the day the services are rendered unless specific arrangements are made in writing, in advance.

For those patients who are covered by insurance, you authorize your insurance company to pay all insurance benefits otherwise payable to you to Main Street Family Dentistry, P.A., for services rendered and hereby assign those benefits to Main Street Family Dentistry, P.A. This means that you sign the portion of your insurance form that "assigns" payment to our office. Most dental insurance plans DO NOT COVER 100% of the cost of your treatment. Because of this and extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your estimated portion of the charges the day the services are rendered.

We estimate your coverage as closely as possible, but until we actually receive payment from the insurance company, it is just an estimate. We will assist you in dealing with your insurance company, but the ultimate responsibility for payment by your insurance company lies with you. After 45 days, any remaining balance not covered or received from your insurance company will be due in full from you.

Until your accounts are finally settled, you give direct consent to receive communications regarding your accounts from any servicers and any collectors of your accounts, through various means such as: any cell, landline or text number that you provide, any email address that you provide, auto dialer system, voicemail messages, and other forms of communications.

Payments are due and payable to Main Street Family Dentistry's place of business at 627 West Main Street, Tupelo, MS 38804. If this account is referred for collection, debtor agrees to pay Main Street Family Dentistry, P.A. an additional 33 1/3% of the original bill (including interest) or $150.00 (minimum) as attorney fees, plus all pre-judgment cost of collections to include court cost. Debtor consents to the jurisdiction of the Lee County, Mississippi court system for enforcement of payment of this account. Debtor agrees to pay interest on all overdue amounts at the rate of 1.25% per month (15% annual percentage rate) or such other lesser amount as is allowed by the laws of the state of MS. As part of the consideration of extending credit to you, you hereby agree to pay the above account and be personally liable for all charges on the account made by any of your family members or persons residing in your household.

Feel free to ask any questions that remain unanswered either before or after treatment. We wish to help you all we can.

I have read the above and agree to its terms. _____

(Patient's Signature)

Witness _____ Date _____

Dr. Brett M. Hildenbrand | Dr. Harry J. Rayburn | Dr. Michael M. Monroe

627 West Main Street | Tupelo, MS 38804 | 662.840.0066 | www.mainstreetdentistrytupelo.com

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CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take X-rays, study models, photography, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any potential complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service and that I may request a copy of the financial policy at any time.

5. Lastly, I understand that my insurance company works for me and any nonpayment from them to Main Street Family Dentistry, P.A. is still my personal responsibility.

Patient's Signature _____ Date _____

Parent or Responsible Party _____

Relationship to Patient _____

Witness _____ Date _____

Dr. Brett M. Hildenbrand | Dr. Harry J. Rayburn | Dr. Michael M. Monroe

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