Today's Date:_____

PATIENT INFORMATION

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ext.____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Email Address_____

You may send me appointment reminders through ☐ Text Messages ☐ Email ☐ Phone Calls Only

Date of Birth:_____ Social Security Number:_____ DL#_____

Employer:_____ Occupation:_____

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

Whom may we thank for referring you? _____

Other immediate family members seen by us:_____

Person to contact in case of emergency_____ Phone(_____)_____

Family Member or Neighbor not living with you:_____ Relation:_____

Phone (_____)_____ We will only use this contact if your phone numbers change and we are unable to reach you.

SPOUSE INFORMATION

Spouse's Name:_____ Date of Birth:_____ SSN:_____

Employer_____ Work Phone (_____) _____ext.____ Cell Phone (_____)_____

RESPONSIBLE PARTY

(if "Self" only Billing Address needs to be completed if different than above)

Name:_____ Relationship to Patient: _____

Billing Address (if different than above):_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ext.____ Cell Phone (_____)_____

Date of Birth:_____ DL:_____ SSN:_____

Dental Care of Flora, PLLC - Brad A. Franklin, DMD
106 Central Blvd - P.O. Box 126 - Flora, MS - 39071
p. 601-879-0031 – f. 601-879-8474

DENTAL INSURANCE

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (___)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE A SECONDARY INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (___)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

MEDICAL HISTORY

Are you currently being treated by a physician? ☐ Yes ☐ No Reason:_____

Please list **all** medications you are taking:_____

Do you smoke or use tobacco? ☐ Yes ☐ No Do you have any metal rods, implants or pins? ☐ Yes ☐ No

Are you pregnant at this time? ☐ Yes ☐ No Are you nursing at this time? ☐ Yes ☐ No

Have you ever taken Fosamax or biphosphonate? ☐ Yes ☐ No

Please answer each question. **HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?** (Please place an "X")

YES	NO		YES	NO		YES	NO	
☐	☐	Abnormal Bleeding	☐	☐	Heart Murmur	☐	☐	Osteoporosis / Paget's Disease
☐	☐	Alcohol/Drug Abuse	☐	☐	Heart Surgery	☐	☐	Pacemaker
☐	☐	Anemia	☐	☐	Hemophilia	☐	☐	Psychiatric Problems
☐	☐	Arthritis	☐	☐	Hepatitis ___	☐	☐	Radiation Treatment
☐	☐	Artificial Bones/Joints/Valves	☐	☐	Herpes / Fever Blisters	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Cancer/ Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Shingles
☐	☐	Colitis	☐	☐	HIV+ / AIDS	☐	☐	Sickle Cell Disease/ Traits
☐	☐	Congenital Heart Defect	☐	☐	Hospitalized for Any Reason	☐	☐	Sinus Problems
☐	☐	Diabetes	☐	☐	Kidney Problems	☐	☐	Stroke
☐	☐	Difficulty Breathing/ Asthma	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Epilepsy/ Seizures	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis (TB)
☐	☐	Fainting Spells	☐	☐	Lupus	☐	☐	Ulcers
☐	☐	Heart Attack	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease (STD)

Other Medical Condition(s):_____

Are you allergic to any of the following? (Please place an "X")

YES	NO		YES	NO		YES	NO	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Codeine	☐	☐	Latex	☐	☐	Other:_____
☐	☐	Dental Anesthetics	☐	☐	Penicillin			_____

I have completed this form to the best of my knowledge and I understand it is my responsibility to notify this office of any changes. I also understand that this information will be held in the strictest confidence. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Patient Signature:_____Date:_____

DENTAL HISTORY

Previous Dentist:_____ Most recent Dental Exam:_____

Most recent Dental Treatment (When & What):_____ Most recent Dental X-ray:_____

How often do you have your teeth cleaned?: _____3mo. _____4mo. _____ 6mo. _____ 12mo. _____ Never

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

WHAT IS YOUR REASON FOR COMING TODAY? _____

Please indicate which applies to you:

YES	NO	
☐	☐	Do your gums bleed while brushing or flossing?
☐	☐	Are your teeth sensitive to hot/ cold / sweets?
☐	☐	Sore teeth or gums
☐	☐	Dry mouth
☐	☐	An unpleasant taste or odor in your mouth
☐	☐	Jaw problems: TMJ, clicking, popping
☐	☐	Have you lost any teeth. If yes, why? _____
☐	☐	Problems with any previous dental treatment/ anesthetics
☐	☐	Do you play contact sports?
☐	☐	Orthodontic Treatment (Braces) When?_____ Provider?_____
☐	☐	Periodontal Treatment (Gums) When?_____ Provider?_____
☐	☐	Are you unhappy with the appearance of your teeth? If yes, check below all that apply.

☐ Color of Teeth ☐ Crowding ☐ Spaces ☐ Other:_____

☐ ☐ Currently or previously worn a partial or complete denture? If yes, see below.

How long?_____ Are you happy with the comfort, appearance and chewing ability? ☐ Yes ☐ No

PAYMENT NOTICE

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT.

I understand that this office accepts and files insurance as a convenience to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I also understand that I am responsible for payment in full if my insurance company denies or delays making payments in a timely manner. I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company.

Signature:_____ Date:_____