Dental Group of Magee
1667 HWY 49 South #6
Magee, MS 39111

Lake Garner D.M.D.
Margaret Nichols D.M.D.

Patient Information

Patient Name: _____ Date of Birth: _____
(First) (MI) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Please select one: ☐ Male ☐ Female Age: _____

Patient Employer/School: _____ Occupation: _____ Email: _____

Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Best time to reach you is: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name: _____ Relationship: _____

Home: (____)_____ Work: (_____)_____ Cell (_____)_____

Please Select One:

☐ Married ☐ Divorced ☐ Single ☐ Minor ☐ Widowed

Spouse Name: _____ Spouse Birthdate: _____
(First) (MI) (Last)

Spouse Social Security #: _____ Spouse Employer: _____

Whom may we thank for referring you? _____

Dental Insurance

Insurance Company: _____ Group #: _____

Who is responsible for this account? _____ Union or Local #: _____

Subscriber's Name: _____ Birthdate: _____

Social Security #: _____ Relationship to patient: _____

Employer: _____ Work #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit: _____

Is this patient covered by additional insurance? ☐ Yes ☐ No (If yes, please add the additional information below)

Insurance Company: _____ Group #: _____

Who is responsible for this account? _____ Union or Local #: _____

Employer: _____ Work #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit: _____

Dental History

Reason for today's visit _____ Date of last dental visit? _____

Former Dentist: _____ Phone: _____ Date of last dental Xray? _____

Check if you have or have had a problems with any of the following:

☐ Bad Breath ☐ Clicking or popping jaw ☐ Grinding teeth ☐ Sensitivity to cold or h

☐ Bleeding Gums ☐ Food collecting between teeth ☐ Loose teeth or broken fillings ☐ Sensitivity to sweets

☐ Sores or growths 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-phen?" These include combinations of Lonimin, Adipex,Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux(defenfluramine). ☐ Yes ☐ No

Have you ever 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 _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Check if you have or have had problems with any of the following

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints, Pins
☐ Asthma
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart lesions
☐ Cortisone treatments
☐ Cough, persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ Hernia Repair
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ 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 of medications you are currently taking:

_____

_____

Allergies

☐ **Aspirin** ☐ **Local Anesthetic** ☐ **Iodine** ☐ **Barbiurates (Sleeping Pills)** ☐ **Penicillin**
☐ **Latex** ☐ **Codeine** ☐ **Sulfa** ☐ **None**

Other: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with (Insurance Company) _____ and assign directly to Dental Group of Magee all insurance benefits, If any otherwise payable to me for serviced rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance. Your insurance policy is a contract between you and you insurance company. We are not a party to contact. In the event we do accept assignment of benefits we require that you be prepared to pay the balance of the account that is not covered by your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance. I authorize the use of my signature on all insurance submissions. The above-named dental facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Financial Policy:

Thank you for choosing Garner Dental as your health care provider. We are committed to you treatment being successful. Please understand that payment of our bill is considered part of you treatment. The following is a statement of our financial policy/consent form, which we require you to read and sign prior to any treatment. All patients must complete our information form before seeing the doctor. We expect full payment at the time of service. We will accept cash, checks, MasterCard, Visa, Care Credit, and Comprehensive Finance. Adult patients are responsible for payment at the time of service. Minor patients must have an adult accompanying a minor and guardians are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangement have been made to make payment.

Rates:

All hygiene appointments must be cancelled 24 hours before appointment or a $25.00 no show fee will be added to your account.

_____ Any account we do not receive payment on within 90 days will go to collections, NO EXCEPTIONS
Initial above

_____ Accounts that are 30 days past due will be subject to a $3.00 billing charge per statement along with 1.5% interest rate added to their account.
Initial above

Terms and Agreements:

I assume full responsibility for the bill incurred. I understand that payment is due at the time services are rendered. I further understand that in the event of a returned check a $30.00 fee will be assessed on my account. I also understand and agree if this account goes into default I will be responsible for all court cost, attorney's fees, and collection fees which will total to 35% of the balance of the account at the time of default. I understand that dentistry is not an exact science and successes cannot be guaranteed. I also understand the results of my examination, the proposed treatment, possible complications, and the anticipated results. This includes the administration of local anesthetic/sedation methods (such as laughing gas) may be needed. I also authorize the administration of radiographs as an important and necessary diagnostic tool. If accounts are not paid within 30 days of billing a 1.5% interest rate will be added to me account. I authorize Garner Dental and/or associates and assistants as may be necessary to perform the needed procedures.

I have read the financial policy/consent form. I understand and agree to the terms above.

_____ _____

Signature of Patient or Responsible Party Date

DENTAL GROUP OF MAGEE

NOTICE OF PRIVACY/CONSENT FORM

I, _____, understand that under the Heath 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 healthcare providers who may be involved in that treatment directly and indirectly. I understand that my medical records including x-rays, may be sent via unprotected or unencrypted email or mail. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that if I have a concern about the privacy of my medical records, I can contact the Dental Group of Magee's Office Manager at (601)849-0225 or concerns can be submitted directly to the United States Department of Health and Human Services.

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 do agree then you are bound to abide by such restrictions.

I give the staff of Dental Group of Magee permission to contact me by the following methods:

___ Call me including leaving a message on my voice mail or answering machine.
___ Send emails
___ Send texts
___ Send post cards

Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____