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

[redacted]

☐ 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:** _____

[redacted]

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: _____

[redacted]

NAME: _____ **RELATIONSHIP TO PATIENT:** _____
Last First MI

ADDRESS: _____
Street APT # City State Zip

BIRTHDATE: _____ **AGE:** _____ **SS#:** _____

HOME PHONE: _____ **CELL:** _____ **EMAIL:** _____

PLACE OF EMPLOYMENT: _____ **PHONE:** _____

[redacted]

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**

[redacted]

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: _____

[redacted]

	YES	NO		YES	NO		YES	NO
Heart Disease	☐	☐	Diabetes	☐	☐	AIDS/HIV Positive	☐	☐
Heart Murmur*	☐	☐	Cold Sores	☐	☐	Hypoglycemia	☐	☐
Drug Addiction	☐	☐	Angina/Chest Pains	☐	☐	Lung Disease	☐	☐
Liver Disease	☐	☐	Heart Attack/Failure	☐	☐	Breathing Problems	☐	☐
Hepatitis A/B/C	☐	☐	Herpes	☐	☐	Mitral Valve Prolapse*	☐	☐
Stroke	☐	☐	Scarlet Fever	☐	☐	Hay Fever	☐	☐
Convulsions	☐	☐	Rheumatic Fever*	☐	☐	Artificial Heart Valve*	☐	☐
Sinus Trouble	☐	☐	Kidney Problems	☐	☐	Renal Dialysis	☐	☐
Epilepsy/Seizures	☐	☐	Pacemaker	☐	☐	Heart Surgery*	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Stomach Disease	☐	☐
Ulcers	☐	☐	Glaucoma	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Thyroid	☐	☐
Pain in Jaw Joint	☐	☐	Artificial Joints*	☐	☐	Tumors/Growths	☐	☐
Allergies (Pollen/Dust)	☐	☐	Cancer	☐	☐	Chemotherapy	☐	☐

Steroid Therapy ☐ ☐	Organ Transplant* ☐ ☐	Nervousness ☐ ☐
Asthma ☐ ☐	Radiation ☐ ☐	Arthritis/Gout ☐ ☐
Rheumatism ☐ ☐	Psychiatric Care ☐ ☐	Fainting/Dizziness ☐ ☐
Excessive Bleeding ☐ ☐	Sleep Apnea ☐ ☐	Other ☐ ☐

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

[redacted]

Name of previous dentist: _____
Date of last dental visit: _____
How long since last cleaning? _____
Reason for changing dentist: _____
Describe your current dental problem: _____

[redacted]

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

[redacted]

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

[redacted]

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

[redacted]

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

[redacted]

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: _____

[redacted]

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**

[redacted]

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**

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**