STARKVILLESMILES
Barry W. Herring, D.M.D.
Jonathan A. Woolfolk D.M.D
301 Hospital Rd., Starkville, MS 39759

Patient Name: _____

Whom may we thank for referring you to our office? _____

Have you been hospitalized during the past 2 years? _____

Are you currently under the care of a physician? Yes____ No ____
Physician's Name: _____

Have you ever had? (Answer Yes or No):

Abnormal bleeding	_____	Heart Disease	_____
Adrenal disorder	_____	Heart Murmur	_____
AIDS or related complex	_____	Heart Pacemaker	_____
Allergies to metal, jewelry	_____	Hepatitis	_____
Arthritis	_____	HPV	_____
Artificial Heart Valve	_____	Kidney Disease	_____
Artificial Joint (s)	_____	Latex Allergy	_____
Asthma	_____	Liver Disease	_____
Cancer Therapy	_____	Lung Disease	_____
Convulsions/Seizures	_____	Lupus	_____
Redux/Fenphen Diet pills	_____	Mitral Valve Prolapse	_____
Diabetes	_____	Emphysema	_____
Rheumatic Fever	_____	Thyroid Disorder	_____
Grinding Teeth	_____	Stroke	_____
Low Blood Pressure	_____	Thumb Sucking Habit	_____
High Blood Pressure	_____	Multiple Sclerosis	_____

Do you or a family member

- Snore? _____ -choke or gasp during sleep? _____
- Wake frequently? _____ - feel tired or fatigued? _____
- Had a sleep study or been prescribed a CPAP? _____

Are you currently taking Bisphosphanate drugs?
(Fosamax, Actonel, or Boniva) Yes ___ No ____If yes, for how long? _____

Are you taking any medicines now? YES NO

If yes, list them: _____

Preferred Pharmacy: _____

Are you allergic to any medicines? YES NO

If yes, list them: _____

WOMEN: Are you pregnant? YES NO

The medical information I have provided is true and accurate to the best of my knowledge.

Signed _____ Date_____

STARKVILLESMILES
BARRY W. HERRING D.M.D
JONATHAN A. WOOLFOLK D.M.D

FAMILY DENTISTRY **COMMITTED TO EXCELLENCE**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that, under the Health 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 heathcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent, I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

Starkville Smiles
Barry W. Herring D.M.D./Jonathan A. Woolfolk D.M.D.
301 Hospital Road, Starkville, MS 39759
Phone: 662-323-3245; Fax 662-323-6004

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 understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

STARKVILLESMILES
Barry W. Herring. D. M. D.
Jonathan A. Woolfolk D.M.D.
301 Hospital Rd., Starkville, MS 39759

Patient Legal Name: _____ Goes by: _____
First Middle Last

Address: _____City _____

State _____Zip_____ **E-mail-Address**:_____

Phone (H) _____(W1)_____(W2)_____(cell)_____

D.O.B. ____/____/_____Sex (m)_____ (f) _____ Marital: (s) ___(m)___(d)___(w)___

S. S. N. (for identification purposes) _____

Parent/Guardian's Name: _____Relation to child _____

S.S.N. _____ D.O.B. _____/_____/_____

Phone#: _____

Address (if different than child's) _____

Is patient a full time student? _____ Where? _____

FOR DENTAL INSURED PATIENTS

Employee/Ins. Holder's Name:_____

D.O.B. _____S.S.N: _____Relation to _____

Phone#: _____Cell Phone#: _____

Address (if different than patient's) _____

Employer_____Address_____

Insurance Co. _____

Group # _____ID#_____

Address_____

(Ph#)_____

*** I am responsible for all costs of dental treatment.

*** I authorize release of any information related to my dental insurance claims.

*** I authorize payment of group ins. Benefits directly to Barry W. Herring, D.M.D.

*** I have received a copy of Payment of Fees.

***I would like to receive statements by e-mail Yes___ No___

Signed _____ **Date**_____

If you would like to receive your STATEMENTS by Email:

Patient Name (PRINT): _____

We now have the capability of sending your statement via email. If you would like to receive your statement by email please provide us with a valid email address.

E-Mail Address: _____

Patient Signature: _____ **Date:** _____

Decline ☐