STARKVILLE Smiles

301 Hospital Rd • Starkville, MS 39759
(662)323-3245 • www.StarkvilleSmiles.com

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	_____

During your sleep, do you:

- Snore _____ - Choke or gasp during sleep _____
- Wake frequently _____ - Feel tired or fatigued _____
- Have you had a sleep study or been prescribed a CPAP _____

Do you use any of the following products:

- Cigarettes_____ Smokeless Tobacco____ Vape/E-Cig____
- Chewing Tobacco_____

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_____

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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*.

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: ____

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

Address: _____ **APT#** _____City _____

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

Phone (H) _____(Cell) _____(W1)_____(W2)_____

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

S. S. N. (for identification purposes) _____-_____-_____
Full Time Student (yes or no): _____

FOR DENTAL INSURED PATIENTS

Policy Holder's Name:_____ Relation to patient_____

D.O.B. _____/_____/_____ SSN _____ Phone _____

Address (if different than patient's) _____

Employer_____Insurance Co. _____

ID # _____ Group # _____ INS phone # _____

Insurance Address_____

RESPONSIBLE PARTY (Responsible for balance due)

Name: _____ D.O.B:_____

SSN: _____Relation to Patient: _____

Address (if different than patients'): _____

City: _____State: _____ Zip: _____

Phone #: _____ Email Address: _____

I would like to receive my statements by Email ☐ Mail ☐

(Please READ THE FOLLOWING CAREFULLY and make sure you understand)

****I understand I am responsible for cost of dental treatment**

****Any outstanding balance will be billed to me directly**

****I am responsible for any amount not paid by my insurance**

Signed ___________________________________ Date____________________