AIRPARK
FAMILY DENTISTRY

1060 Holland Ave – Philadelphia, MS 39350
Ph: (601)656-3275 Email: airparkfamilydentistry@yahoo.com

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

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

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

DOB: ____/____/____ SSN: ____-____-____ Sex: M/F Marital: S/M/D/W

For Insured Patients

Policy Holder Name: _____

DOB: ____/____/____ SSN: ____-____-____ Relation to patient: _____

Phone: _____ Address(if different than patients'): _____

Employer: _____ INS Company: _____

ID#: _____ Group #: _____

INS Address: _____ INS Phone #: _____

Responsible Party (this would be the person responsible for any balance after insurance payment)

Name: _____ Relations to Patient: _____

Mailing Address: _____ Phone: _____

DOB: ____/____/____ SSN: ____-____-____

PLEASE READ THE FOLLOWING CAREFULLY THEN SIGN AND DATE

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

***I authorize and consent to the release of necessary information to my dental insurance company

***I authorize payment of group benefits to Airpark Family Dentistry

Signed: _____ Date: _____

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We have two doctors at our office, Dr. Steele and Dr. Saxon, that work cohesively together. If you are scheduled for a cleaning with one of our hygienists, you will have your teeth cleaned followed by an examination by one of our doctors. Our hygienist will usually get the first available dentist to prevent you from having to wait extended lengths of time for your exam. However, if you have a special request or preference, please feel free to tell your hygienist. You can also receive your exam from one doctor but schedule any needed further treatment with another. We are all one cohesive team here and our goal is to provide excellent care for all of our patients.

List any recent surgeries or hospitalizations here: _____

Please mark "x" to indicate you currently or have ever had any of the following conditions:

Abnormal Bleeding	_____	HPV	_____
Adrenal Disorder	_____	Kidney Disease	_____
AIDS	_____	Liver Disease	_____
Anemia	_____	Low Blood Pressure	_____
Arthritis	_____	Lung Disease/COPD/Emphysema	_____
Artificial Joints	_____	Lupus	_____
Artificial Valves	_____	Migraines	_____
Asthma	_____	Mitral Valve Prolapse	_____
Cancer/Chemotherapy	_____	Multiple Sclerosis	_____
Chronic Pain	_____	Osteoporosis	_____
Congestive Heart Failure	_____	Pacemaker	_____
Convulsions/Seizures	_____	Reflux	_____
Dementia	_____	Respiratory Problems	_____
Diabetes	_____	Rocky Mtn. Spotted Fever	_____
Epilepsy	_____	Sinus Problems	_____
Grinding or Clenching teeth	_____	Stroke	_____
Heart Attack/ Disease/	_____	Thumb Sucking Habit	_____
Murmur	_____	Thyroid Disorder	_____
Hepatitis	_____	Ulcers	_____
High Blood Pressure	_____		

**IF YOU HAVE HAD A STROKE, HEART ATTACK OR JOINT REPLACEMENT PLEASE LIST THE DATE OF THOSE EVENTS HERE:_____

**ARE YOU CURRENTLY TAKING A BLOOD THINNER? YES_____ NO _____

If yes, list the medication here: _____

Please mark "x" to indicate you currently or have ever had any of the following conditions:

Bipolar _____

Schizophrenia _____

ADHD _____

Autism _____

Sensory processing disorder _____

Anxiety _____

Depression _____

Other mental health information that you would like us to know

_____

***In case of emergency we may contact: _____ Phone: _____

_____

Are you taking any medications currently? If yes, please list them: _____

_____

_____

Do you have any allergies/Are you allergic to any medications? Please list them here: _____

_____

_____

_____

Preferred Pharmacy: _____

Are you pregnant? Y/N If yes, how many weeks?_____

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

Signed _____ Date_____

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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 healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment 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.
Airpark Family Dentistry
1060 Holland Avenue
Philadelphia, MS 39350
Phone: 601-656-3275
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.

Signed _____ Date _____

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Authorization for release of Dental and Health information

Patient Name (please print): _____

I give permission for Airpark Family Dentistry to release my (or my child) Dental records and/or health history to the following friends and /or family members if the occasion arises and is needed. By signing this form, I also give Airpark Family Dentistry permission to send my Dental records/x-rays/health history (etc....) to any appropriate doctor, clinic, or hospital for continuing care if my needs cannot be met here:

1._____(Relationship)_____

2._____(Relationship)_____

3._____(Relationship)_____

Patient/Guardian Signature: _____

Date: _____

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No Show Policy

If you need to reschedule your appointment, we ask that you give us at least 24 hours notice. We realize that emergencies happen, but we still ask that you notify us as soon as possible in order for us to schedule other patients.

2 Missed Appointments could result in dismissal as a patient.

If you are running late, please kindly call our office to be sure that we can still work you in. We have a 15 minute cut off for adults and 10 minute cut off for children cleanings so that we may keep our schedule running smoothly in respect for other patients.

X Patient/Parent or Guardian

Signature_____Date_____