LeFleur Dental Group

1437 Old Square Road, Suite 105 Jackson, MS 39211

PATIENT INFORMATION	DATE	<u> </u>
NAME		
ADDRESS		
(STREET) (APT#) (G	CITY) (STATE) (ZIP)	
HOME PHONE NUMBER ()	OFFICE PHONE NUMBER ()	
EMAIL ADDRESS	CELL NUMBER ()	
DATE OF BIRTH PLACE OF BIRTH	SEX MARITAL STATUS	
PATIENT'S SOCIAL SECURITY NUMBER		
PATIENT'S EMPLOYER	OCCUPATION	7.0. 24.
EMPLOYER'S ADDRESS		
PERSON RESPONSIBLE FOR PATIENT ACCOUNT	1	
ADDRESS	PHONE NUMBER () _	
DATE OF BIRTH SOCIAL SECURITY NU	JMBER	 -
IF PATIENT IS A CHILD MOM'S NAME	FATHER'S	
HOW DOES THE RESPONSIBLE PERSON PLAN T RECEIVES HERE: (CIRCLE BELOW)	O PAY FOR THE DENTAL CARE PATIENT	ſ
CASH/CHECK PAYMENT		
CREDIT CARD		
DENTAL INSURANCE		
CARE CREDIT		
PRIMARY INSURANCE:	SECONDARY INSURANCE:	
NAME OF COMPANY		_
POLICY HOLDER POLICY HOLDER SS#		_
POLICY HOLDER D/O/B		
EMPLOYER		
WHO REFERRED YOU TO OUR CLINIC?		
WHO SHOULD WE CONTACT IN CASE OF EMER	GENCY?	
PHONE	NUMBER ()	

*PLEASE BE AWARE THAT PAYMENT FOR FIRST VISIT WILL BE REQUIRED AT TIME OF VISIT OUR OFFICE WILL BE HAPPY TO ASSIST IN FILING INSURANCE ON FOLLOWING VISITS.

1. ARE YOU UNDER THE CARE OF A PHYSICIAN? IF SO, WHAT IS THE CONDITION BEING TREATED? 2. THE NAME AND ADDRESS OF MY PHYSICIAN 3. HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION RECENTLY? IF SO, WHAT WAS THE ILLNESS OR OPERATION? 4. DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING? YES NO A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE () () () () () () () () () () () () ()	HE	ALTH HISTORY QUESTIONAIRE	D	ATE			
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	11	DO YOU USE TOBACCO?	()	()	

DATE			YES	NO	
12. DO YOU HAVE ANY DISEASE, CON LISTED ABOVE I SHOULD KNOW A	DITION (OR PROBLEM NOT	()	()	
13. WOMEN - ARE YOU PREGNANT			()	()	
14. DO YOU HAVE ANY OF THE FOLLO	OWING? (OR HAVE YOU EVER	HAD?	,	
MOUTH	YES	NO		YES	NO
BLEEDING, SORE GUMS UNPLEASANT BAD BREATH FREQUENT BLISTER MOUTH/LIPS SWELLING/LUMPS IN MOUTH BITING CHEEKS/LIPS CLICKING/POPPING JAW SHIFTING IN BITE 15. ARE YOU PLEASED WITH THE APP IF NOT, WHAT WOULD YOU LIKE T	() () () () () () EARANC	() LOOSE TEET () SENSITIVE T () SENSITIVE T () SENSITIVE T () CLENCHING () IF SO, WHEN () CHANGE IN E OF YOUR TEETH A GE ABOUT THE APP	O HOT O COLD O BITING G/GRINDING BITE AND SMILE?	()	() () () ()
16. LAST DENTAL EXAM	— <u></u>	_ LAST DENTAL X R.	AYS		
IF YOU ARE COMPLETING THIS FORM					-
TO MY KNOWLEDGE, ALL OF THE PRE HAVE A CHANGE IN MY HEALTH OR C DENTIST AT MY NEXT APPOINTMENT. SIGNATURE OF PATIENT DATE	HANGE I	ANSWERS ARE TRUEN MY MEDICATION,	I WILL INF	RECT. IF ORM TH	I EVER IE

LeFleur Dental Group

NO-SHOW POLICY

A patient is considered a no-show if he/she fails to notify the dental clinic if they cannot make their appointment at least 2 hours before their scheduled appointment. If they fail to notify the clinic, then they are subject to a \$50 no-show-fee. This will be charged via credit card or debit card by the clinic only at time of no show. No charges will be made otherwise.

This policy is to insure that we can properly schedule and treat our patients in a timely and efficient manner. We appreciate your understanding and please do not hesitate to ask any questions.

Signature:	Date:
Name	
Name:	
Card Type:	
Card #:	
Exp. Date:	
Security Code:	

LeFleur Dental Group

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this form

Please Print Name of Patient
LeFleur Dental Group has my permission to speak to concerning my treatment/account. Please Print Name of Patient
Please Print Name of Patient Signature of Patient or Power
Signature of Patient or Parent
organistic of 1 attent of Parent
Date
FOR OFFICE USE ONLY
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
Individual refused to sign
Communication barriers prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgment
Other (please specify)