PLEASE PRINT

Colony Dental

Sarah Carlisle, D.M.D
119 Colony Crossing, Suite 780
Madison, MS 39110
(601) 605-1410

Date_____ Home Phone (____)_____ Cell Phone (____)_____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name_____ Preferred Name_____ SS#_____

Address_____ E-mail_____

City_____ State_____ Zip_____ Driver's License #_____

Sex ☐ M ☐ F Age_____ Birthdate_____ Married ☐ Single ☐ Child ☐ Other ☐

Patient's Employer_____ Occupation _____

Patient's School_____ Employer Phone (____)_____

In case of an emergency, who should be notified?_____ _____ Phone (____)_____

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

DENTAL INSURANCE INFORMATION

PRIMARY

Insured's Name (Person who carries the insurance)_____

Relation to Patient_____ Birthdate_____ Social Security #_____

Insured's Employer _____ Employer Phone (____)_____

Dental Insurance Carrier_____

Insurance Address_____

Insurance Phone (____)_____ Policy ID #_____ Group#_____

Is the patient covered by any other ***dental*** insurance policy? Yes ☐ No ☐

SECONDARY

Insured's Name (Person who carries the insurance)_____

Relation to Patient_____ Birthdate_____ Social Security #_____

Insured's Employer _____ Employer Phone (____)_____

Dental Insurance Carrier_____

Insurance Address_____

Insurance Phone (____)_____ Policy ID #_____ Group#_____

I certify that I, and /or my dependents, have insurance coverage with_____ and assign directly to Colony Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining my insurance benefits. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature _____ Today's Date _____

PLEASE PRINT

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental Care_____

Former Dentist_____ Date of last Dental X-rays_____

Former Dentist Address/Phone_____

Check ☑ if you have had problems with any of the following:

__Bad breath	__ Grinding teeth	__ Sensitivity to hot
__ Sensitivity to cold	__ Sensitivity to sweets	__ Sensitivity when biting
__ Bleeding Gums	__ Loose Teeth/Broken Filling	__ Clicking or popping of jaw
__ Periodontal Treatment	__ Food Collection between teeth	__ Sores or growths in mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Medical Physician's Name_____ Date of last Visit_____

Have you used a Bisphosphonate medication? (Common brands are Fosamax, Actonel, Atelvia, & Boniva) ☐ Yes ☐ No If yes, which one(s)_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date(s)_____

WOMEN Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Currently taking birth control pills? ☐ Yes ☐ No

Check ☑ if you have or have had any of the following:

__Anemia	__Cough, Persistent	__ Hepatitis	__Rheumatic Fever
__Arthritis, Rheumatism	__Cough up Blood	__ Herpes Simplex Virus	__Shortness of Breath
__Artificial Heart Valves	__Diabetes	__High Blood Pressure	__Skin Rash (Current)
__Artificial joints	__Epilepsy	__HIV/Aids Virus	__Stroke
__Asthma	__Fainting	__Jaw Pain	__Thyroid Disease
__Back problems	__Glaucoma	__Kidney Disease	__Tobacco Habit
__Cancer(type)_____	__Headaches	__Liver Disease	__Tuberculosis
__Chemical Dependency	__Heart Murmur	__Mitral Valve Prolapse	__Ulcer
__Chemotherapy	__Heart Problems	__Pacemaker	__Other_____
__Circulatory Problems	__Hemophilia	__Radiation Therapy	

MEDICATIONS

List **ALL** medications you are currently taking:

_____

_____

_____

Preferred Pharmacy_____

Phone_____

ALLERGIES

__ Aspirin	__ Sulfa
__Barbiturates	__Latex
__Codeine	__Other_____
__ Local Anesthetic	_____
__Penicillin	

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

Colony Dental

To Our Appreciated Patient,

It is our desire to constantly improve services and quality of care for you so that you can regain and maintain your dental health as quickly, efficiently and inexpensively as possible. Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office. Therefore, the following must be agreed upon:

1. Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or wellbeing-we are. As a courtesy, we will provide you with an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. As a reminder, we cannot be responsible for what your insurance will or will not cover.

2. Timeliness is required. We will see you on time and get you out on time unless there is an unforeseen emergency. We request that you be on time for your visits. **If you are more than 10 minutes late, you may have to reschedule your appointment**. Cleanliness and infection control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. This is an important reason why we demand timeliness of you and ourselves.

3. If you miss an appointment, it is critical to your health to make it up so to avoid setbacks in the care and maintenance of your teeth and gums. Failure to make an appointment not only compromises your health but it also inconveniences other patients who may have requested an office visit during your reserved appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to give us notice 48 business hours before the appointment to reschedule. There is a **$100 fee for all no-show and cancelled appointments w/o 48 hour business day notice**. This fee is not covered by insurance.

4. We strive to run a Zero Balance office. In order to achieve this **we require 50% of your total patient out of pocket expense to reserve any scheduled appointment**. We have several financial options available for all of our patients. Please speak with our business office manager if you have any questions regarding financial options.

5. Emergencies: It is our goal to eliminate all of the potential dental emergencies that you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. We define a true emergency as swelling, bleeding, severe pain that has kept you up at night or requires medication or a restoration in a visible area that falls out. If you experience any of these conditions, we ask that you call us right away. We will provide you with the next available emergency appointment. We set aside time daily for emergencies.

Yours in Dental Health,

Dr. Sarah C. Carlisle

I have read and agree to the terms of the Appreciated Patient Letter.

_____ _____ _____

(Patient Signature) (Patient's Printed Name) (Date)

_____

(Team Signature)