Penley Family Dentistry

601-749-9330

Patient Information

Home Phone__________ Cell Phone__________ Emg. Phone __________

Name(Last, First, Middle Initial)__________ SS# __________

Address__________ City__________ State_____ Zip _____

Mailing Address (if different)__________ City__________ State_____ Zip _____

Sex(circle one): Male Female Age_____ Birthdate________ Marital Status: Single Married Widowed Divorced Separated

Patient Employed By__________ Occupation __________

Email __________ Whom may we thank for referring you? __________

Emergency Contact__________ Phone__________ Relationship__________

Spouse's Name__________ Spouse DOB__________ Spouse SS# __________

Spouse's Employer__________ Work Phone__________ Cell Phone__________

MEDICAL INSURANCE

Responsible Party (Last, First, Middle Initial) __________

Relationship to Patient__________ DOB__________ SS#__________

Address (if different from patient) __________

Responsible Party Employer__________ Occupation __________

DENTAL INSURANCE

Responsible Party (Last, First, Middle Initial) __________

Relationship to Patient__________ DOB__________ SS#__________

Address (if different from patient) __________

Responsible Party Employer__________ Occupation __________

Notice of Privacy Rights

I understand that my healthcare information concerning my diagnosis, treatment, payment and insurance will be disclosed when necessary for filling my insurance and in communication with other healthcare professionals in the course of my treatment at their labs, hospitals, accountants, computer support, billing personnel, answering services and consultants. These businesses are restricted in the use and disclosure of my information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for my healthcare with my knowledge, we may disclose information to that family member or person.

I understand that my files are stored on shelves in the business office and electronically on office computers. Only staff and janitorial personnel may have access to this office during non-business hours. I understand that this office will make every effort to keep my information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy or inspect and correct my healthcare information, the right to restrict disclosures and obtain any accounting of disclosures. I have the right to voice my concerns about privacy to the practice and/or Secretary of Health and Human Services within 180 days of my discovery of disclosure violation without fear of retaliatory acts by this office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. (A minimal fee of .20 per page will be charged to me for copies of records I request.)

I understand that I will receive communication in the form of phone calls and/or phone calls/text/e-mails and/or postcards to remind me of an existing appointment or that it is time to schedule an appointment. I may receive mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the forms of fax or e-mail or by other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voicemail.

I authorize my insurance Company(s) to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist/Penley Family Dentistry to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Insurance is a contract between you and your insurance company. WE ARE NOT A PARTY TO THIS CONTRACT. We may bill your primary insurance company as a courtesy to you. Although we may ESTIMATE what your insurance may pay, this insurance company makes the final determination of eligibility.

Signature__________ Date__________

Penley Family Dentistry

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question		
Are you under a physician's care now?	O Yes O No	If yes
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes
Have ever had a serious head or neck injury?	O Yes O No	If yes
Are you taking any medications, pills, or drugs?	O Yes O No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No	If yes
Are you on a special diet?	O Yes O No	
Do you use tobacco?	O Yes O No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances? O Yes O No If yes

Other? If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw joints	O Yes O No	Tumors or Growths	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Yellow Jaundice	O Yes O No						

Have you ever had any serious illness not listed O Yes O No If yes

Signature of Patient, Parent or Guardian:______________________________ Date:________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

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Welcome to Penley Family Dentistry

Thank you for choosing Penley Family Dentistry to provide your oral healthcare needs. We know you could go anywhere you wanted for your dentistry. We certainly value your trust in us and we will not take your decision lightly. We strive to make every visit as comfortable as possible. We ask that if we do not meet your expectations to please bring it to the attention of Dr. Penley as soon as possible. Please read the following way we may assist you.

Scheduling Appointments: Dr. Penley and her team are dedicated to providing the best oral health care in the best environment possible. We value scheduling our Doctor's time just for you and will do our best to not keep you waiting. Please honor our trust in you by arriving for your appointment on time and being prepared to pay the amount agreed upon for each visit. Penley Family Dentistry accepts cash, all bank cards, checks and we have partnered with an outside credit company to assist our patients with the cost of dental treatment.

Dental Insurance Facts: 1. Dental Insurance is not meant to be a pay-all. It is only meant to be a supplement. 2. Many plans tell their insured that they'll be covered "up to 80% or 100%." In spite of what you're told, we've found most plans cover less than the average fee. Some plans pay more, some less. The amount your plan is determined by how much your employer paid for the plan. The less the employer paid for the insurance, the less you'll recieve. 3. Many routing dental services are not covered by insurance plans!

Please do not hesitate to ask us any questions. We want you to be comfortable in dealing with these matters, and we urge you to consult us if you have any questions regarding our services and/or fees. If we take assignment on your insurance we feel within 30 days is a reasonable length of time for us to wait for payment from your insurance company, Any amount not paid by your insurance within 30 days becomes due, and your responsibility at that time.

No Insurance, No problem: You can receive a cash discount for your payment in full by cash or check in advance for treatment. You may pay by cash or check only, on the day the treatment is rendered. To further assist you, we have partnered with a finance company that will allow you to extend your payments for twelve months with no interest and up to 60 months with minimal interest. We are happy to assist you with your payment options, please feel free to ask.

Monthly Statements: If there is a balance on your account after insurance, we will send you one statement. It will show separately the previous balance, any new charges to the account, the finance charge and any payments or credits applied to your account during the month.

Payments: The balance on the account is due and payable when the statement is issued and must be paid BEFORE your next dental appointment.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. You agree to incur any cost associated with the collection of your account including, but not limited to any attorney fees, court fees or collection fees.

Returned Checks: There will be a fee of $40.00 for all returned checks.

Wavier of Confidentially: You understand if this account is submitted to an attorney or collection agency if we have to litigate in court, of if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring Records: You must request, in writing, and your account must not be past due for us to transfer your records. You agree to pay your account in full before expecting any documentation from Penley Family Dentistry.

Personal Injury: If you are being treated as a part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements must be determined. Payment of bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

By executing this agreement, you are agreeing to pay all services that are received. And agree to abide by the office policy on scheduling, record transferring and my account balance.

Patient's/Responsible Party Name ______________________________ Date ____________________

Signature ____ Date ____________________

Penley Family Dentistry

6480 Highway 11 North
Carriere, MS 39426
601-749-9330

Records Release/Request

Date: ____________________

To: ________________________________

Phone: ______________________________ Fax: ______________________________

Email Address: ____

I, ___________________________, hereby authorize the release of the records and x-rays/or copies of such and be transferred immediately to: ____________________________________

Penley Family Dentistry
Dr. Adrienne Penley, DMD
6480 Hwy 11 North
Carriere, MS 39426
T: 601-749-9330
F: 601-749-9449
penleyfd@gmail.com

Patient Print Name: ________________________________ DOB: ______________

Patient's Signature: ________________________________ Date: ______________

Parent/Guardian Signature: ____