DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____ ID#/SS#_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation_____

Employer_____

Employer Address_____

Employer Phone (_____)_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ 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 paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home(_____)_____ Work(_____)_____ Ext_____ Spouse's Work(_____)_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

4 DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss?_____

How often do you brush?_____

5 HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
			Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Phone (_____)_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Thames Dental

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April, 15, 2003_, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Thames Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

PLEASE READ CAREFULLY!

PATIENT CONSENT FORM

I, _____do hereby give my legal consent to Dr. W. A. Thames to perform the services which have been explained to me on myself_____, my child_____, my ward _____, with the exception of _____. I have also given a true and accurate medical history to Dr. Thames because I understand that medical problems past or present, prescribed medication, and over the counter medication can have dangerous consequences during and after dental treatment.

I understand that drugs used in the dental office can have adverse effects such as allergic reactions, drowsiness, and stomach upset. The risks and the potential side effects of these drugs have been explained to me.

I understand that during extractions of lower teeth a jaw fracture may occur or temporary to permanent numbness of the lip or tongue may occur. Extraction of upper teeth may result in an exposure of the maxillary sinus which can be difficult to close. Existing restorations may be damaged, and infection may result. As with all dental treatment cuts and abrasions may occur in the course of treatment.

I understand that root canal therapy is not always successful, especially with badly infected teeth and extraction may be necessary after root canal therapy is done.

I understand that any filling, crown, bridge, or any other restoration may turn out to be more complex than originally anticipated and require more complex therapy. An example is a tooth which has a cavity deeper than expected may require a root canal and a crown rather than a filling.

I understand that all efforts will be made to insure the occlusal harmony of restorations but that sometimes tempromandibular joint pain may occur as a result or from other causes.

The usual complications which may result from my treatment have been explained. I realize that I may ask any more questions I want to and I may refuse any treatment recommended.

I accept that complications can arise from treatment and medication beyond the dentist's control and that good oral health is also my responsibility and often failure of dental therapy is due to patient neglect. I accept that these and other complications may result from my treatment and I do not and will not hold Dr. Thames and his staff liable for complications which occur beyond his control.

I understand that I may strike out any sentence or paragraph with a pen which I do not agree with. I will write any comments pertaining to my consent here:_____

_____

_____

I may cancel this consent at any time after a specific procedure is completed for future treatment but not for treatment already performed.

Signed _____ Date _____

Thames Family Dentistry W.A. Thames, DMD* J.F. Jones, DMD* J.A. Jackson, DDS

Understanding Our Office

*We will gladly file your insurance as a courtesy to you. Anything not covered by your insurance is your responsibility. We estimate your portion at the time of service and this is due when service is rendered. (Once insurance pays, we will know your exact portion.)

*Upon your request, we will gladly send a pre-authorization to insurance for services. (This is the only way to know your exact cost on a procedure.)

*Our office is amalgam free. We offer composite fillings (tooth colored) exclusively.

*Certain things are not covered or may be down-graded by your insurance. It is your responsibility to know what your insurance covers. (The insurance will issue a booklet that explains your coverage.)

*Occasionally you will be asked to pay in-advance for treatment. In addition, a deposit may be required for certain appointments.

*It is your responsibility to inform us of any changes in your insurance and health history.

In the exam room...

*Upon examination, you will be charted. The chart appears on the screen in front of you at each appointment. Any proposed treatment will appear as Red/Maroon. Any existing work you presented with will appear as Black. So there is never any confusion about your progress, the work completed will change from Red/Maroon to Blue/Green.

*Please defer any questions regarding insurance or prices to the front office. (The doctors cannot assist you with any of this information.)

*We are a practice of general dentists, occasionally you may be referred to a specialist. We will be happy to make these appointments for you upon your request.

We offer interest free payment plans through third party financing.
We will be happy to assist you in applying for these services.

I _____
I understand the above information.

Thanks, Stephani Hawkins
Office Manager

Thames Family Dentistry, PLLC

9035 E Sandidge, Ste. A | OLIVE BRANCH MS, 38654 | (662) 895-7338

Written Financial Policy

Thank you for choosing Thames Family Dentistry, PLLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit and Chase
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Thames Family Dentistry, PLLC requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Our office requires an insured patient to leave a credit card on file in the event your insurance doesn't cover for all or partial services received. Your privacy is our concern; therefore your credit card and all other personal information will be stored in your personal chart. If you incur a balance, we will contact you and explain in detail what was not covered by your insurance, why, and how much you are responsible for, then ask for permission to charge the card left on file.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $25 is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice.

Thames Family Dentistry, PLLC charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. Interest and late fees may apply to past due accounts.

Thames Dental

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

CareCredit® APPLICATION AND CREDIT CARD ACCOUNT AGREEMENT

A credit service of GE Capital Retail Bank

For Providers: **(800) 859-9975**
For Patients/Clients: **(800) 365-8295**
Submit by internet: **CARECREDIT.COM**

** **MARRIED WI Residents only:** If you are applying for an individual account and your spouse also is a WI resident, combine your and your spouse's financial information.

ESTIMATED FEE $	**Office Merchant #**	Pre-Approval Offer ❑ Accepted ❑ Refused Date _____

Photo ID verified (initial):	Applicant 1st ID Type / Number # _____ ❑ Driver's License ❑ State Issued ❑ Federal Government	Issuance State	Exp. Date	Applicant 2nd ID Type / Issuer	Exp. Date
Provided by GE Capital Retail Bank:	Account #	Authorization # or Key #		Approved Credit Limit	

1. APPLICANT INFORMATION: Please tell us about yourself. Please note that you must reside in the United States and be 18 years or older to apply.

Name (First-Middle-Last) Please Print	Date of Birth / /	Social Security Number - -	Home Phone Number* ( )

Mailing Address	Apt.#	City	State	Zip	Cell/Other Phone Number* ( )

If the above address is a P.O. Box, you **must** provide a street address for yourself or a contact person. ❑ Your Address? ❑ Contact Person?
Contact Person Name | Street Address (Street Name and Number) | City | State | Zip

Housing Information ❑ PARENTS/RELATIVE ❑ OWN ❑ RENT ❑ OTHER	Nearest Relative Phone Number* ( )	Alimony, child support or separate maintenance income need not be included unless relied upon for credit. You may include the monthly amount that you have available to spend from your assets. **	Monthly Net Income From All Sources $_____	Employer's Phone Number* ( )

E-Mail Address (optional)*

*You authorize GE Capital Retail Bank ("GECRB") to contact you at each phone number you have provided. By providing a cell phone number and/or email address, you agree to receive special offers, updates and account information, including text messages, from Providers that accept the GECRB credit card. Standard text messaging rates may apply.

2. JOINT INFORMATION:

An additional card will be issued to the person indicated below. The applicant (and joint applicant, if any) will be liable for all transactions made on the account including those made by any authorized user. JOINT APPLICANT: You agree that we may send notices to you and/or applicant at the applicant's address, regardless of whether you live at that address.

Name (First-Middle-Last) Please Print	Date of Birth / /	Social Security Number - -	Home Phone Number * ( )

Mailing Address	Apt.#	City	State	Zip	Cell/Other Phone Number * ( )

If the above address is a P.O. Box, you **must** provide a street address for yourself or a contact person. ❑ Your Address? ❑ Contact Person?
Contact Person Name | Street Address (Street Name and Number) | City | State | Zip

Housing Information ❑ PARENTS/RELATIVE ❑ OWN ❑ RENT ❑ OTHER	Nearest Relative Phone Number * ( )	Alimony, child support or separate maintenance income need not be included unless relied upon for credit. You may include the monthly amount that you have available to spend from your assets. **	Monthly Net Income From All Sources $_____	Employer's Phone Number * ( )

Joint Applicant ID Type / Number # _____ ❑ Driver's License ❑ State Issued ❑ Federal Government	Issuance State	Exp. Date	Joint Applicant 2nd ID Type / Issuer	Exp. Date

E-Mail Address (optional)*

*You authorize GE Capital Retail Bank ("GECRB") to contact you at each phone number you have provided. By providing a cell phone number and/or email address, you agree to receive special offers, updates and account information, including text messages, from Providers that accept the GECRB credit card. Standard text messaging rates may apply.

3. APPLICANT and JOINT APPLICANT: We need your signature(s) below.

By applying for this account, I am asking GE Capital Retail Bank ("GECRB") to issue me a CareCredit Credit Card (the "Card"), and I agree that:

- I am providing the information in this application to CareCredit LLC, participating professionals that accept the Card and program sponsors. GECRB may provide information about me (even if my application is declined) to CareCredit LLC, participating professionals that accept the Card and program sponsors (and their respective affiliates) so that they can create and update their records, and provide me with service and special offers.
- GECRB may obtain information from others about me (including requesting reports from consumer reporting agencies and other sources) to evaluate my application, and to review, maintain or collect my account.
- I consent to GECRB and any other owner or servicer of my account contacting me about my account, including using any contact information or cell phone numbers I provide, and I consent to the use of any automatic telephone dialing system and/or an artificial or prerecorded voice when contacting me, even if I am charged for the call under my phone plan.
- I have read and agree to the credit terms and other disclosures in this application, and I understand that if my application is approved, the GECRB credit card account agreement ("Agreement") will govern my account. Among other things, the Agreement: **(1) includes a resolving a dispute with arbitration provision that limits my rights unless I reject the provision by following the provision's instructions;** and (2) makes each applicant responsible for paying the entire amount of the credit extended.

PLEASE SEE NEXT PAGE FOR RATES, FEES AND OTHER COST INFORMATION.

Federal law requires GECRB to obtain, verify and record information that identifies you when you open an account. GECRB will use your name, address, date of birth, and other information for this purpose.

If I have been pre-approved, I request that you open the type of account for which I was pre-approved. I have read the Prescreen Disclosures, credit terms and other disclosures on the next pages and have been provided my credit limit applicable to the account. **GECRB reserves the right to refuse to open an account in my name if GECRB determines that I no longer meet GECRB's credit criteria or if I do not meet GECRB's debt to income requirements.**

If you apply with a Joint Applicant, each of you will be jointly and individually responsible for obligations under the Agreement and by signing below, you each agree that you intend to apply for joint credit.

Signature of Applicant		Signature of Joint Applicant (If Applicable)	
X_____ (Please Do Not Print)	Date_____	X_____ (Please Do Not Print)	Date_____