MATTHEW FAIRBURN, DMD

FAMILY AND COSMETIC DENTISTRY

445 Northpark Dr. | Ridgeland, MS 39157

I understand this is a fee-for-service practice and all fees are due and payable at the time of service. We accept cash, check, and most major credit cards and Care Credit® financing. I understand that a service fee may be assessed on any past due accounts and an interest rate of 1.5% per month or 18% per year may be assessed on any accounts greater that 90 days past due. THIS WILL APPLY TO ALL ACCOUNT BALANCES INCLUDING THOSE THAT EXIST WHEN INSURANCE COMPANIES DELAY MAKING THEIR PAYMENTS. I agree to pay any reasonable cost incurred by Northeast Dental in attempting to collect past due accounts as are due from me, including collection cost, legal fees, and court costs. I understand there will be a $20 service charge for any returned checks.

_____

Patient or Representative Name (please Print)

_____ _____

Patient or Representative Signature Date

office: 601-956-4007 fax: 601-956-2901

DENTAL HISTORY

Referred by: _____

Previous Dentist: _____ Most Recent Dental Exam? _____

Most Recent Dental X-Ray? _____ Most Recent Dental Treatment? _____

How often do you have your teeth cleaned? 3 mo.____ 4 mo.____ 6 mo.____ 1 year or longer_____

WHAT IS YOUR MOST IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO	
1. Unhappy with the appearance of your teeth.....	☐	☐	
Check all that apply. ☐ Color of Teeth ☐ Crowded Teeth ☐ Spaces ☐ Shape ☐ Unsightly Fillings and/or Crowns			
2. Unfavorable Dental Experiences.....	☐	☐	
3. Problems with Effectiveness or bad reactions to dental anesthetic.....	☐	☐	
4. Orthodontic Treatment (Braces).....	☐	☐	When?_____
5. Periodontal Treatment (Gum).....	☐	☐	When?_____
6. Bleeding Gums.....	☐	☐	
7. Avoid brushing any part of your mouth.....	☐	☐	
8. Part of your mouth is sensitive to temperature and your sweets.....	☐	☐	
9. Sore teeth.....	☐	☐	
10. A burning sensation in your mouth.....	☐	☐	
11. An unpleasant taste or odor in your mouth.....	☐	☐	
12. Dry mouth, throat, and or eyes.....	☐	☐	
13. Jaw problems (tempromandibular joint).....	☐	☐	
14. Clench or grind your teeth.....	☐	☐	
15. Jaw clicking or popping.....	☐	☐	
16. Lost any teeth.....	☐	☐	
17. Do you play contact sports?.....	☐	☐	

SUPPLEMENTAL DENTURE HISTORY:
If you are wearing a partial or complete denture, please complete the following:

YES	NO	
☐	☐	Has your present denture been relined? If so, when? _____
☐	☐	Is your present denture a problem? Describe _____
☐	☐	Satisfied with the appearance? _____
☐	☐	Satisfied with the comfort? _____
☐	☐	Satisfied with the chewing ability? _____
		When did you receive your first partial or complete denture? _____
		How long have you worn your present denture? _____

PATIENT'S SIGNATURE _____ DATE: _____

NORTHEAST DENTAL
FAMILY AND COSMETIC DENTISTRY
C. DAVID WEST, DDS • MATTHEW FAIRBURN, DMD

Patient Information

Name _____
First Last Initial

Email _____

Is Patient's mailing address different than the billing address
(circle one) Yes No

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____

Cell Phone (_____) _____

Would you like to receive texts and email? ❑ Yes ❑ No

Birthday _____ / _____ / _____

Sex (circle one) Male / Female

Marital status (circle one)

Single / Married / Divorced / Widowed

Whom may we contact in case of emergency

Phone Number (_____) _____

Name _____

Relationship _____

Regular Dentist _____

How did you hear about our practice? (please check one)

- Family member * ❑
- Another patient * ❑ Name: _____
- Referred by Dr. * ❑ Name: _____
- Insurance * ❑
- Yellow Pages ❑
- Walk In ❑
- Other * ❑
- Google ❑

If Full Time Student:
School Name _____

City _____

Medical History

Purpose of appointment? _____ Date of last dental visit _____

Are you currently being treated by a physician? _____

Are you taking **ANY** medication? (List) _____

Are you pregnant at this time? ❑ YES ❑ NO

Please answer each question. **HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?** (Please place an "**X**").

YES	NO		YES	NO	
❑	❑	Heart Trouble	❑	❑	Epilepsy
❑	❑	Heart Murmur	❑	❑	Tuberculosis
❑	❑	Circulatory Trouble	❑	❑	Kidney Trouble
❑	❑	Rheumatic Fever	❑	❑	High Blood Pressure
❑	❑	Low Blood Pressure	❑	❑	Anemia or Easy Bruising
❑	❑	Prolonged or Unusual Bleeding	❑	❑	Diabetes
❑	❑	Liver or Other Glandular Disease	❑	❑	Herpes Simplex or Cold Sores
❑	❑	AIDS (HIV Positive)	❑	❑	ARC (Aids Related Complex)
❑	❑	Nervous Breakdown or Emotional Disturbance	❑	❑	Reaction to Anesthetic
			❑	❑	Reaction to Drugs, Penicillin or Other Antibiotics

PLEASE LIST: _____

_____

Have you had Hepatitis? ❑ YES ❑ NO Are you a Hepatitis carrier? ❑ YES ❑ NO

Please indicate the **TYPE** of Hepatitis you have? _____

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated.

SIGN X _____ Date _____

Billing Information

if different from address on front - this is not your dental insurance address

Bill to the attention of: _____

Address _____
Street City State Zip

Phone Number _____

How will you be paying for services rendered? (please check one) ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ CARE CREDIT

Employment Information

(*If a patient is a minor, a parent or guardian will complete below information.)
Please fill out even if you do not have dental insurance

PRIMARY POLICY HOLDER

First Name & MI _____

Last Name _____

Birthday _____

Social Security # _____

D.L. # _____ State _____

Employer _____

Address _____

City _____ State _____ Zip _____

Work Ph. # _____ Ext. _____ O.K. to call? Y/N

SECONDARY POLICY HOLDER

First Name & MI _____

Last Name _____

Birthday _____

Social Security # _____

D.L. # _____ State _____

Employer _____

Address _____

City _____ State _____ Zip _____

Work Ph. # _____ Ext. _____ O.K. to call? Y/N

Dental Insurance Information

PRIMARY POLICY HOLDER

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Insurance Phone _____

Group # _____

How is the patient covered by this insurance? (check one)
❑ Primary ❑ Secondary ❑ Not Covered

What is patient's relationship to this employee? (check one)
❑ Self ❑ Spouse ❑ Child ❑ Other

SECONDARY POLICY HOLDER

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Insurance Phone _____

Group # _____

How is the patient covered by this insurance? (check one)
❑ Primary ❑ Secondary ❑ Not Covered

What is patient's relationship to this employee? (check one)
❑ Self ❑ Spouse ❑ Child ❑ Other

I personally accept responsibility for professional services rendered and agree that any balance not covered or paid by my insurance company within a 60 day period of filing will be payable in full. Any unpaid balance beyond 60 days will accrue interest at a rate of 1 1/2% per month unless prior arrangements have been made.

Signature X _____ Date _____

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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 to receipt of our Notice of Privacy Practices, but acknowledgement could not obtained because:

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

office 601-956-4007 fax 601-956-2301