THE SMILE CENTER OF CLARKSDALE

Dr. Joseph Shleweet, D.D.S.
526 South Choctaw St., Suites B & C • Clarksdale, MS 38614 • (662) 627-3633

PATIENT INFORMATION

Name _____ MR. / MRS. / MS. / DR. _____ 7/2 FNAME
LAST FIRST MI TITLE (CIRCLE ONE) SAL. (OFFICE USE)

Address _____
NUMBER & STREET CITY STATE ZIP

Mailing Address If Different From Above _____ Cell # _____

___-___-___ (___) ___-___ ___ (___) ___-___ ___ ___ FPURN MDXWSU
SOC. SEC. NUMBER AREA CODE HOME PHONE AREA CODE BUSINESS PHONE EXT EMPL. MARITAL ST.

M F _____ _____ _____ _____
SEX DATE OF BIRTH YOUR OCCUPATION EMPLOYER YRS. WITH FIRM

Parents Name If A Minor _____ PREFER AM OR PM - SHORT NOTICE OKAY

RESPONSIBLE PARTY INFORMATION

_____ _____ _____
RESPONSIBLE PARTY OCCUPATION EMPLOYER YEARS WITH FIRM

Name _____ MR. / MRS. / MS. / DR.
LAST FIRST MI TITLE (CIRCLE ONE)

Address _____
NUMBER & STREET CITY STATE ZIP

___-___-___ (___) ___-___ (___) ___-___ ___ M F _____
SOC. SEC. NUMBER AREA CODE HOME PHONE AREA CODE BUSINESS PHONE EXT SEX DATE OF BIRTH

Has Anyone In Your Family Seen Dr. Ware? _____ If so, who? _____

If You Are Completing This Form For Another Person, What Is Your Relationship To That Person? _____

DENTAL INSURANCE INFORMATION

Employer _____
COMPANY NAME ADDRESS - NUMBER & STREET CITY/STATE/ZIP

( )
_____ _____ _____
GROUP NAME GROUP NUMBER EMPLOYER'S PHONE NUMBER

( )
_____ _____ _____ _____ _____
INSURANCE COMPANY NAME ADDRESS NUMBER & STREET CITY/STATE/ZIP INS. CO. PHONE EXT.

We Need A Copy Of Your Insurance Card

ADDITIONAL INFORMATION

Spouse _____ / / - -
FIRST NAME MI DATE OF BIRTH SOCIAL SECURITY NUMBER

( )
_____ _____ _____ _____ _____
SPOUSE'S OCCUPATION EMPLOYER YRS. WITH FIRM BUSINESS PHONE EXT.

I Wish To Pay By ○ Cash ○ Check ○ Credit Card

EMERGENCY CONTACT

( ) ( )
_____ _____ _____ _____
LAST NAME FIRST NAME WORK PHONE HOME PHONE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

I understand that payment is expected when services are rendered unless other arrangements are made in advance. A monthly service charge of 1-1/2% per month (18% per year) will be added on all accounts not paid within 30 days. We file your insurance as a courtesy. Insurance claims not paid in 60 days are your responsibility.

OVER

HEALTH HISTORY

Although dental personnel primarily treats 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:

Are you under a physician's care now? ❒ Yes ❒ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ❒ Yes ❒ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ❒ Yes ❒ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ❒ Yes ❒ No If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux? ❒ Yes ❒ No If yes, please explain: _____
Are you on a special diet? ❒ Yes ❒ No If yes, please explain: _____
Do you use tobacco? ❒ Yes ❒ No If yes, please explain: _____
Do you use controlled substances? ❒ Yes ❒ No If yes, please explain: _____

WOMEN: ARE YOU:
Pregnant / Trying to get pregnant? ❒ Yes ❒ No Taking oral contraceptives? ❒ Yes ❒ No Nursing? ❒ Yes ❒ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:
❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Acrylic ❒ Metal ❒ Latex ❒ Local Anesthetics
❒ Other If yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

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

Have you ever had any serious illness not listed above? ❒ Yes ❒ No If yes, please explain: _____

_____

Comments: _____

_____

_____

_____

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 dentist office of any changes in medical status.

Signature of patient, parent, or guardian _____ Date _____

PAYMENT POLICY

To insure that we understand how you wish your account to be handled, please check the payment method you prefer and sign on the space indicated below. You can mark more than one payment (i.e. check and insurance).

_____ CASH _____ CHECK _____ CREDIT CARD _____ CARE CREDIT _____ DENTAL INSURANCE

ASSIGNMENT OF BENEFITS

My signature below authorizes payment to The Smile Center of Clarksdale, LLC and/or Dr. Joseph K. Shleweet for payment or reimbursement of any insurance benefits otherwise payable to me.

CONSENT FOR USE AND DISCOLOSURE OF HEALTH INFORMATION

As indicated by my signature below, I hereby authorize The Smile Center of Clarksdale, LLC and/or Dr. Joseph K. Shleweet to release all protected health information to carry out treatment, payment activities and healthcare operations as described more fully in "Notice of Privacy Practices".

ACKOWLEDGEMENT OF "NOTICE OF PRIVACY PRACTICES"

I understand a "Notice of Privacy Practices" is posted in the waiting area. I can obtain a copy at my request.

I have hereby read, understand and agree to all of the afore written policies that are currently in effect with The Smile Center of Clarksdale, LLC and/or Joseph Shleweet, DDS as validated by my signature below.

Patient Name: _____
(please print)

Sign: _____ **Date:** _____
(please state relationship if other than patient)