Tupelo Dental Group

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form.
If you have any questions, we will be glad to help you.

Patient Information

Date _____ Name _____
Last First MI

Phone _____ Social Security Number _____ Date of Birth _____

Address _____

City _____ State _____ ZIP Code _____

Sex ☐ M ☐ F **Marital Status** ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated/Divorced

Patient Employer _____ Occupation _____ Business Phone _____

Employer Address _____
Street City State ZIP Code

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Primary Insurance

Person Responsible for Account _____ Relationship _____
Last First MI

Phone _____ Social Security Number _____ Date of Birth _____

Address (if different) _____
Street City State ZIP Code

Employer _____ Occupation _____ Business Phone _____

Employer Address _____
Street City State ZIP Code

Insurance Company _____

Policy Number _____ Group Number _____ Subscriber Number _____

Names of Other Dependents _____

If you have additional insurance, please notify the front desk.

Dental History

Reason for Today's Visit _____ Date of Last Dental Care _____

Former Dentist _____ Date of Last Dental X-Rays _____

Address _____
Street City State ZIP Code

Place a check mark in the box if you have had problems with any of the following:

- ☐ Discomfort, clicking or popping in jaw
- ☐ Red, swollen or bleeding gums
- ☐ Sensitive tooth, teeth or gums
- ☐ Blisters/sores in or around mouth
- ☐ Lost/broken fillings
- ☐ Teeth grinding
- ☐ Ringing in ears
- ☐ Broken/chipped tooth
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Other:

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

Medical History

Do you have any heart conditions that require pre-medication? ☐ Yes ☐ No

Cardiologist name: _____

Do you have any joint replacements that require pre-medication? ☐ Yes ☐ No

Surgeon name: _____

Have you ever taken: ☐ Bisphosphonates (ex. Aredia/Fosamax) ☐ Phen-fen/Redux

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No On birth control? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No How much/long? _____

Place a check mark in the box if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis/Rheumatism	☐ Cough, Persistent	☐ HIV / AIDS / ARC	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ Jaw Pain	☐ Sinusitis/Sinus Problems
☐ Artificial Bones/Joints	☐ Diabetes	☐ Kidney Problems	☐ Skin Rash
☐ Asthma	☐ Epilepsy/Seizures	☐ Liver Problems	☐ Stroke
☐ Back Problems	☐ Fainting	☐ Low Blood Pressure	☐ Swelling of Feet or Ankles
☐ Blood Disease	☐ Headaches/Migraines	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Cancer/Tumors	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory Problems	☐ Ulcer
☐ Circulatory Problems	☐ Hepatitis	☐ Rheumatic Fever	☐ Other: _____

List medications you are currently taking _____

_____

_____

Allergies _____

_____

_____

List any surgeries or medical conditions you have or ever had

_____

_____

I authorize my insurance company to pay to Tupelo 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 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.

Signature _____ Date _____

Adult Patient Parent or Guardian Spouse