William P. Dickey III, DMD, PLLC
Family Dentistry
142 Jefferson Davis Boulevard, Suite B
Natchez, Mississippi

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to ask us.

PATIENT INFORMTION

Name:_____ **D.O.B:**_____

Address:_____ **City:**_____ **State:** _____ **Zip:**_____

Social Security #: _____ **Driver's License #:**_____

Home Phone: (___**)**_____ **Work Phone: (**____**)**_____ **Cell Phone: (**___**)**_____

Sex: ☐ **M** ☐ **F** ☐ **Married** ☐ **Widowed** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Partnered**

E-mail address: _____

Employer/School:_____ **Employer/School Phone #: (**___**)**_____

Employer/School Address:_____ **City:** _____ **State:**____ **Zip:**_____

Spouse or Parent's Name:_____ **Contact #: (**____**)**_____

Emergency Contact:_____ **Phone #: (**____**)**_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account:_____ **Relation to Patient:**_____

Address:_____ **City:**_____ **State:** _____ **Zip:**_____

D.O.B.:_____ **Driver's License #:**_____ **Bank:**_____

Employer:_____ **Work Phone(**____**)**_____

Currently a patient in our office: ☐ **Yes** ☐ **No** **Cell #: (**____**)**_____

INSURANCE INFORMATION

Name of Insured:_____ **Relation to Patient:**_____

D.O.B:_____ **Social Security #:** _____ **Date Employed:**_____

Employer:_____ **Employer Phone #: (**___**)**_____

Employer Address:_____ **City:** _____ **State:**_____ **Zip:**_____

Insurance Company:_____ **Group #:**_____

Address:_____ **City:**_____ **State:** _____ **Zip:**_____

How much is your deductible? _____ **How much have you used?** _____ **Max Annual Benefit:** _____

DENTAL HISTORY

Reason for today's visit:_____ Date of last dental care:_____

Former Dentist: _____Date of last dental x-rays: _____

Address:_____ City:_____ State: _____ Zip:_____

Mark if you have had problems with any of the following:

___Bad Breath	___Grinding Teeth	___Sensitivity to hot
___Bleeding Gums	___Loose teeth or broken fillings	___Sensitivity to sweets
___Clicking or popping jaw	___Periodontal treatment	___Sensitivity when biting
___Food collection between teeth	___Sensitivity to cold	___Sores or growths in your mouth

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

MEDICAL HISTORY

Physician's Name:_____ Date of last visit:_____

Address:_____ Phone #: (____)_____

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

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe:_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates:_____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Mark if you have or have had any of the following:

___Anemia	__ Congenital Heart Lesions	__ Hepatitis	__Scarlet Fever
___Arthritis, Rheumatism	___Cortisone Treatments	___Hernia Repair	___Shortness of Breath
___Artificial Heart Valves	___Cough, Persistent	___High Blood Pressure	___Skin Rash
___Artificial Joints, Pins, etc.	___Cough up Blood	___HIV/AIDS	___Stroke
___Swelling of Feet and Ankles	___Diabetes	___Jaw Pain	___Asthma
___Back Problems	___Thyroid Problems	___Kidney Disease	___ Epilepsy
___Bleeding Abnormally	___Fainting	___Liver Disease	___Glaucoma
___Blood Disease	___Tobacco Habit	___Mitral Valve Prolapse	___Tonsillitis
___Cancer	___Headaches	___Pacemaker	___Tuberculosis
___Chemical Dependency	___Heart Murmur	___Radiation Treatment	___Ulcer
___Chemotherapy	___Heart Problems	___Respiratory Disease	___ Hemophilia
___Circulatory Problems	___Venereal Disease	___Rheumatic Fever	

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

_____

_____

Drug Allergies:

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the Patient Information, Responsible Party, Insurance Information, Dental History, and Medical History is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with _____ _____ and assign directly to William P. Dickey III, DMD, PLLC 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, and all costs incurred in the collection of those fees. I authorize the use of my signature on all insurance submissions.

Name of Insurance Company

William P. Dickey III, DMD, PLLC may use my health care information and may disclose such information to any necessary insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Please Initial the following:

_____ **I give permission to William P. Dickey III, DMD, PLLC to leave messages regarding my appointment(s) at my home/cell phone number.**

_____ **I give permission to William P. Dickey III, DMD, PLLC to leave messages regarding my appointment(s) at my work phone number.**

Please List the following:

Dr. William P. Dickey III, DMD, PLLC has permission to discuss appointments and treatment with the following individual(s):

1. _____
2. _____
3. _____

Signature of Patient, Parent Guardian or Personal Representative **Date**

_____ _____

Print Name of Parent, Guardian or Personal Representative **Relationship to Patient**

_____ _____