Date: _____

perkins dental

A breath of fresh air.

Jessica Perkins, DDS
Carla Cole, DMD

Perkins Dental Clinic | 212 Oxford Rd. | New Albany, MS | (662) 534-8597 | perkinsdentalclinic.com

Patient Information:

First Name: _____ Last: _____ Middle: _____

Preferred Name: _____ Male/Female Marital Status: _____

Social Security Number: _____ Drivers License Number: _____ Date of Birth: _____

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

Cell Phone: (_____)_____ Work Phone: (_____)_____ Home Phone: (_____)_____

E-Mail Address: _____ Employer: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: (_____)_____

Responsible Party Information (for minors or those in care of a legal guardian):

First Name: _____ Last Name: _____ Relation to Patient: _____ Male/Female (Please circle)

Social Security Number: _____ Drivers License Number:_____ Date of Birth: _____

Address (if other than patient): _____ City: _____ State: _____ Zip Code: _____

Phone Number (if other than patient): (_____)_____ E-mail Address(if other than patient): _____

Insurance Information:

Primary Insurance Company Name: _____ Policy Holder Name: _____ DOB: _____

Policy Holder SSN (if other than patient): _____ Policy Holder Employer (if other than patient): _____

Member ID: _____ Plan/Group Number: _____

Secondary Insurance Company Name: _____ Policy Holder Name: _____ DOB: _____

Policy Holder SSN (if other than patient): _____ Policy Holder Employer (if other than patient): _____

Member ID: _____ Plan/Group Number: _____

New Patients Only:

Is any member of your immediate family (minor child or spouse) a patient at Perkins Dental? If yes, please list below:

_____

How did you learn about us? Facebook/Instagram Google Newspaper/Magazine Friend/Family: _____ Other: _____

The undersigned hereby authorize Jessica Perkins, DDS and/or Carla Cole, DMD to take radiographs, study models, photographs or any other diagnostic aids deemed necessary by Jessica Perkins, DDS and/or Carla Cole, DMD to make a thorough diagnosis of the patient's dental needs. I also authorize Jessica Perkins, DDS and/or Carla Cole, DMD to perform any and all forms of treatment, medication and therapy that may be indicated. All information on this page and all other forms provided to me is correct and fully understood by me. I understand the financial policy and all assign all insurance benefits, if applicable, to Jessica Perkins, DDS and/or Carla Cole, DMD.

Patient or Guardian Signature: X_____ Date: _____

Dental Health History

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Please Check Yes (Y) to any of the following that apply to you:

Y		Y	
❑	Sensitivity (hot, cold, sweets, pressure)	❑	Bleeding, Swollen or Irritated Gums
❑	Chipped / Broken Teeth	❑	Dissatisfied with Appearance of My Teeth
❑	Crooked or Tipped Teeth	❑	Frequent Headaches
❑	Loose Teeth	❑	Jaw Joint Pain
❑	Missing or Spaces Between Teeth	❑	Grinding or Clenching Teeth
❑	Catch Food Between Teeth	❑	Uncomfortable or Uneven When I Bite My Teeth Together
❑	Dry Mouth or Constantly Thirsty	❑	Clicking or Popping of Jaw
❑	Smoke or Use Chewing Tobacco	❑	Difficulty Opening or Chewing

Please Check Yes (Y) if you have, or had any of the following:

Y		Y	
❑	Dentures or Partials	❑	Veneers
❑	Braces or Clear Braces	❑	Jaw Surgery
❑	Periodontal Disease or Gum Treatments	❑	Root Canals
❑	Fixed Bridge	❑	Sleep Apnea
❑	Dental Implants	❑	C-PAP Machine or Oral Sleep Appliance
❑	Crowns	❑	Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

❑ Make My Teeth Whiter	❑ Repair Chipped Teeth
❑ Make My Teeth Straighter	❑ Replace Missing Teeth
❑ Close Spaces or Gaps That Bother Me	❑ Replace Old Crowns That Look Dark/Don't Match
❑ Replace Dark Metal Fillings with Tooth-Colored Fillings	❑ Have a Smile Makeover
❑ Fix My Teeth So I'm Not Embarrassed When I Smile	❑ Stop My Jaw From Hurting or Clicking

On a scale of 1 to 10 with 10 being the highest: (Please circle)

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

If this is your first time in our office, please answer the following:

Date of last cleaning? _____ / _____ Date of last oral cancer screening? _____ / _____

Date of last complete x-rays? _____ / _____

What is the most important thing to you about your visit today? _____

_____

Why did you leave your previous dentist? _____

_____

Medical Health History

Please Check Yes (Y) or No (N) for those that apply to you:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Anemia	❑	❑	Emphysema	❑	❑	Kidney Disease	❑	❑	Seizures
❑	❑	Arthritis	❑	❑	Excessive Bleeding	❑	❑	Liver Disease	❑	❑	Stomach Problems
❑	❑	Artificial Heart Valve	❑	❑	Fainting	❑	❑	Low Blood Pressure	❑	❑	Stroke
❑	❑	Artificial Joints	❑	❑	Glaucoma	❑	❑	Mitral Valve Prolapse	❑	❑	Thyroid Disease
❑	❑	Asthma	❑	❑	Heart Conditions	❑	❑	Nervousness/Depression	❑	❑	Tuberculosis
❑	❑	Blood Disease	❑	❑	Heart Lesions	❑	❑	Pacemaker	❑	❑	Ulcers
❑	❑	Bruise Easily	❑	❑	Heart Murmur	❑	❑	Periodontal Disease	❑	❑	STD
❑	❑	Cancer	❑	❑	Heart Surgery	❑	❑	Radiation (Head/Neck)	❑	❑	Other _____
❑	❑	Chemotherapy	❑	❑	Hepatitis: A B C	❑	❑	Respiratory Problems	**Women Only**		
❑	❑	Diabetes	❑	❑	High Blood Pressure	❑	❑	Rheumatic Fever	❑	❑	Birth Control
❑	❑	Dizziness	❑	❑	HIV Positive	❑	❑	Rheumatism	❑	❑	Nursing
❑	❑	Drug Addiction	❑	❑	Jaundice	❑	❑	Scarlet Fever	❑	❑	Pregnant

Expected Due Date:_____

Do you have any of the following drug allergies?

Y	N		Y	N		Y	N	
❑	❑	Aspirin	❑	❑	Latex	❑	❑	Percodan
❑	❑	Codeine	❑	❑	Anesthetic	❑	❑	Penicillin
❑	❑	Darvon	❑	❑	Nitrous Oxide	❑	❑	Antibiotics
❑	❑	Erythromycin	❑	❑	Sulfa	❑	❑	Valium

Please list other allergies:

_____

_____

_____

Please Check Yes (Y) or No (N) if you have taken any of the following drugs at any time:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Fosamax	❑	❑	Didronel	❑	❑	Zometa	❑	❑	Boniva
❑	❑	Aredia	❑	❑	Actonel	❑	❑	Skelid	❑	❑	Bisphosphonates

Please list ALL medications you currently take: *(Prescription & Over-the-Counter. Attach List if Needed)*

_____ _____ _____

_____ _____ _____

Pharmacy Name & Location: _____

Please list ALL surgeries with approximated dates:

_____ _____ _____

_____ _____ _____

Is there any other information regarding your past medical history we should know about?

_____

If under a physician's care, please explain:_____

Physician's Name: _____ Physician's Phone: _____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Perkins Dental of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Perkins Dental or its employees liable in the event of death or injury.

Patient or Guardian Signature: X_____ Date: _____

Our Commitment to You

When a dental appointment is made at our office, a specific & allotted amount of time is reserved just for you.

This appointment time allows the Perkins Dental team to set the schedule to meet your individual needs as well as the needs of others. Last minute cancelations or missed appointments result in the loss of valuable time that could be spent with patients in need of care.

Should you need to cancel or reschedule an appointment with one of our doctors, we respectfully ask that you notify us at least 48 hours in advance of your scheduled appointment time.

In the event you need to reschedule your regular, new patient, scaling & root planing, or periodontal maintenance hygiene appointment, please notify us as soon as possible, but at least 30 days in advance of your scheduled appointment time.

Two no-show appointments may result in your dismissal from our practice. Due to our practice size and the high demand of our dental appointments, we are unable to accommodate patients who habitually fail to commit to their reserved appointments.

Appointment Confirmations: As part of our commitment to you, the Perkins Dental team will make every effort to remind you of your upcoming appointments by text and/or phone call so that you stay on track with maintaining your oral health. We respectfully ask for your cooperation. Please notify our team that you will be here for your reserved appointment as soon as possible. Appointments that are not confirmed within 24 hours of their scheduled time may be cancelled by our team to accommodate patients on our waiting lists.

We truly appreciate your cooperation and thank you for trusting us with your dental care.

Patient or Guardian Signature: X_____ Date: _____

HIPPA Authorization Form

This document allows Perkins Dental to share patient's personal medical information with all persons listed below. If you are the patient or patient's guardian, please provide a list of anyone Perkins Dental may share patient's information with. For minor patients, please list anyone who is allowed to accompany the minor patient to dental appointments or schedule future visits on your behalf. (Example: Spouse, Additional Parent/Guardian, Grandparent)

PATIENT NAME: _____ **DOB**: _____/_____/_____

Name	Phone Number	Relation to Patient

I authorize Perkins Dental to release any and all medical information and results that may pertain to the patient, to the individual(s) listed above.

I authorize Perkins Dental to contact the individuals(s) listed above to convey any pertinent information if I am unable to be reached by the facility.

I authorize that the listed individual(s) are allowed to accompany the minor patient listed above (if applicable) to any appointment and schedule follow ups and treatment visits.

I understand that I may revoke/cancel this authorization by notifying Perkins Dental in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

Patient or Guardian Signature: X_____ Date: _____

Prior Express Consent Form

(Communication Authorization)

I understand that it is important for **JMAC Smiles, LLC dba Perkins Dental** "Service Provider" or an Authorized Entity (as defined below) to be able to communicate with me and have current information about me, my address, my phone number(s), and any other information about me that may assist Service Provider or an Authorized Entity in locating me or communicating with me. In consideration of Service Provider or Authorized Entity providing me services and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, Consumer expressly consents and agrees to the terms and conditions contained in this Prior Express Consent Form.

Authorized Entities: The term "Authorized Entities" shall mean the above referenced Service Provider and any related or affiliated health care provider, physician, service provider, independent contractor (including but not limited to billing services) and each of their respective successors, assigns, agents, attorneys, insurers, representatives, employees, officers, shareholders, partners, parents, subsidiaries, affiliated entities, and all agents and representatives of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of the previously listed persons/entities, including any collection agency or debt collector retained or hired by any of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of them. The term Authorized Entities shall also include any person or entity conducting business or providing services relating to health care at the same physical location at which the Service Provider or any of the previously listed persons/entities conducts some or all its business, and any person or entity Consumer is referred to by Service Provider, and any person or entity who provides health care services related to the services provided by Service Provider.

Communication Consent: I understand that the purpose of this agreement is to authorize the delivery of calls to me, including, but not limited to, using an automatic telephone dialing system or an artificial or prerecorded voice, or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call (hereinafter "Authorized Communications"). I also understand that my agreement to the terms of this Prior Express Consent Form is not a condition of any Authorized Entity's willingness to provide services to me. To the extent permitted by applicable law, and without limiting any other rights the Authorized Entities may have, I expressly consent and authorize the Authorized Entities to communicate with me for any reason, including reasons related to the services provided by Authorized Entities or services to be provided in the future by the Authorized Entities, including collection of amounts owed for said services, via Authorized Communications at the telephone number or numbers I provide below, or that is provided on my behalf, or any phone number that any Authorized Entity obtains or finds on its own which is not provided by me. In addition, I further expressly consent and authorize the Authorized Entities to communicate with me via SMS text messages, other forms of electronic messages, electronic mail, or other electronic communication sent or directed to me through any medium, no matter how the Authorized Entity obtain such contact information. Any Authorized Entity may communicate with me using any current or future means of communication, even if those means are not now known to the Authorized Entity or Consumer. I authorize all the communication methods described in this paragraph even if I will incur a fee or a cost to receive such communications. I further promise to immediately notify the Authorized Entity if any telephone number or email address or other unique electronic identifier or mode of communication that I provided to any Authorized Entity changes or is no longer used by me. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the Service Provider and any Authorized Entity. Finally, I understand that the Authorized Entities have relied upon my statements contained herein and, on my promise, to fulfill my obligations contained herein.

I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original. This Consent shall ensure to the benefit of and be binding upon my heirs, agents, spouses, executors, administrators, successors, and assigns. I intend for all Authorized Entities to be third party beneficiaries of the consent I have provided herein.

Patient or Guardian Signature: X_____ Date: _____

Social Media Informed Consent

(Authorization for Use and Disclosure of Patient Photo/Video Images for Social Media & Marketing)

Perkins Dental is pleased to participate in social media outlets such as Facebook, Instagram, TikTok, etc. Through these venues, we share team and patient pictures, office updates, new contests, and other fun and helpful information updates that may benefit our patients. With the expressed permission of our patients, we are pleased to share posts welcoming new patients to our practice, congratulating patients completing their treatment, and posting photos of our patient's beautiful new smiles.

PATIENT NAME: _____ **DOB**: _____/_____/_____

- ☐ I give my consent to allow Perkins Dental to post my/my child's images/name on social media.

- ☐ I do not give my consent to allow Perkins Dental to post my/my child's images/name on social media.

If consent is given above, I authorize the use and disclosure of my or my child's name, photo/video images, and/or testimonial for marketing purposes by Perkins Dental. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations. I understand the photographic/video images, and/or testimonial will be used for: social media & marketing for Perkins Dental including, but not limited to Facebook, Instagram, TikTok, Twitter and Perkins Dental's website (www.perkinsdentalclinic.com). I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

If consent is not given above, I understand that the Perkins Dental cannot and will not condition treatment based on my decision.

Patient or Guardian Signature: X_____ Date: _____

CONSENT FOR SERVICES and FINANCIAL POLICY

Thank you for choosing Perkins Dental! We are committed to your successful dental treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. We ask that you read and sign prior to treatment. All patients must read and sign this form before seeing the doctor. As a condition of your treatment by our office, financial arrangements must be made in advance. Our practice depends on reimbursement from patients for the cost incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

FINANCIAL POLICY: Full payment is expected at the time of each visit. For extensive cases, financial arrangements made in advance are available. Dental insurance is an agreement between you and the insurance company. Insurance only assists and DOES NOT relieve one of any financial obligations. We will never allow the limitations of your benefits to compromise the quality of your care.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER & CARE CREDIT

DENTAL INSURANCE: Our office will gladly work with you to help you get the maximum benefit available to you. Most dental insurance plans DO NOT cover 100% of the cost of your treatment. You will be expected to pay your deductible and your ESTIMATED co-payment on the day services are rendered. We will gladly file your insurance claim as a courtesy. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions). Because of these variables, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, you are ultimately responsible for all charges. Please know that we will do everything possible to see that you receive full benefits from your insurance company. If your insurance has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time.

If our doctors are not participating providers in your dental insurance plan, we will gladly file all dental claims for any given treatment, but you are responsible for payment, even if your insurance does not pay the claim.

Regarding Plans Where we are Participating Providers: All estimated portions and deductibles are due prior to treatment. In the event your insurance coverage changes to a plan where we are a non-participating provider, refer to the paragraph above.

IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGE IN INSURANCE PRIOR TO TREATMENT.

TREATMENT PLANS: We prepare Treatment Plan Estimates so patients can understand the estimated cost of their recommended treatment prior to its start. The Treatment Plan Estimate is a good faith attempt to predict the cost of your treatment based on the facts known to us when the estimate is made. As your treatment progresses, your dentist may determine (based on consultation with you) that a different or additional treatment is necessary, and your financial responsibility may change.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our geographical area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS: Adult patients are responsible for full payment at the time of service.

MINOR PATIENTS: The adult accompanying the minor and the parents or guardians of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by credit or debit card, or payment by cash or check at the time service has been verified.

NSF CHECK POLICY: Payments made by check that are not honored by your bank will incur a $40.00 returned check fee. The payment will be reversed from the appropriate account and the appropriate notice required by the State of Mississippi will be issued to the check writer. Returned check reimbursements must be in the form of cash, money order, cashier's check, or certified check.

MISSED APPOINTMENTS: We respectfully request that you give us a minimum of a 48-hour notice to cancel or reschedule your reserved appointment. If you must reschedule a hygiene appointment, please reschedule within 30 days of your recommended recall schedule (Please see "Our Commitment to You" page. If a patient fails to keep an appointment, he or she will run the risk of voiding any warranty on restorative work or becoming ineligible for Bleach Club refills. Please help us serve you better by keeping scheduled appointments.

ASSIGNMENT OF INSURANCE BENEFITS: I understand that services rendered to me by Dr. Perkins and/or Dr. Cole and hygienists (collectively labels as "Provider") are my financial responsibility, and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Provider and I understand that I will fully be responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional service charges above the insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state and federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should me insurance company send payment to me; I will forward the payment to the Provider within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to Provider and bring any balance owed by patient to Provider immediately due and payable.

Patient or Guardian Signature: X_____ Date: _____