



Hilary G. Craddock, DMD
James Anthony Presley, DMD, FAGD

New Patient Forms

Patient Information and Health History

Home Phone _____ Cell Phone _____ Today's Date _____ Age _____
Patient's Name _____ Birthday _____
Single Married Divorced Widowed
Home Address _____ City _____ State _____ Zip _____
Patient's Employer _____ Work Number _____
Business Address _____ City _____ State _____ Zip _____
Person Responsible for Account _____ Home Phone _____
Employed By _____ Business Address _____ Work Phone _____
If Patient is Minor: Father's Birthday _____ Mother's Birthday _____
Patient's Social Security Number _____ Spouse's Social Security Number _____
Spouse's Name (Parent if Minor) _____
Spouse's Employer _____ Work Phone _____
Referred By _____
In Case of Emergency Call _____ Relationship _____
Phone _____ Address _____

Medical Information

Who is your family medical doctor? _____
Specialist? _____
Are you under medical care now? Yes _____ No _____ If so for what? _____
Please list all drugs you are currently taking _____
Are you allergic or have you reacted adversely to any of the following:
() Penicillin () Codeine () Nitrous Oxide
() Erythromycin () Sulfa Drugs () Novocain or other local anesthetic
() Aspirin () Darvon () Other _____
Please indicate with a check if you have or have had any of the following conditions:
() High Blood Pressure () Fainting or Dizzy Spells
() Diabetes () Ulcer or Colitis
() Heart Trouble, Heart Attack, Angina () Stroke
() Congenital Heart Lesion (Murmur) () Asthma
() Hepatitis or Liver Disease of Jaundice () Kidney Problems
() Neurological Problems () Malignancies
() Excessive Bleeding following extractions () Psychiatric Problems
() Radiation or Chemotherapy () Sinus Problems
() Anemia or Blood Problems (Hemophilia) () Eye Disorders or Glaucoma
() Arthritis or Rheumatism () Tuberculosis
() Thyroid Problems () Venereal Disease
() Rheumatic or Scarlet Fever () Epilepsy or Seizures
() Artificial Heart Valve, Pacemaker () Chemical Dependency (Alcohol, Drugs)
() Heart Surgery () AIDS
() Artificial Joints (Hip/Knee)

Women

Are you pregnant? _____ If so, what month? _____
Is there any other Medical information that you feel I should know about? _____

Parent or Patient's Signature _____ Date _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF THE INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

RICHLAND DENTAL GROUP
HILARY G. CRADDOCK, DMD
JAMES ANTHONY PRESLEY, DMD, FAGD
125 WEST HARPER STREET
RICHLAND, MS 39218
(601) 932-5100

**CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF
RECEIPT OF INFORMATION**

State law requires us to obtain your consent for contemplated dental treatment. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and direct Dr. James A. Presley/Dr. Hilary G. Craddock with associates or assistants of his choice to perform needed dental treatment. This includes any necessary or advisable anesthetics.

RISK ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:

I understand that dentistry is not an exact science and that complications may occur despite the best efforts. A partial listing of the risks known to be associated with this treatment and with the associated anesthetics are:

- * Swelling & Bruising which may necessitate staying home for several days
- * Breakage of root(s)
- * Paresthesia (Permanent or transient numbness of the cheeks, gums, teeth, lips, tongue, chin, and face)
- * TMJ dysfunction or worsening of condition
- * Stretching of mouth, which may result in cracking or bruising
- * Instrument breakage
- * Infection
- * Pain
- * Loss of taste
- * Sinus involvement
- * Bleeding may be heavy enough to stop the procedure
- * Loss/damage to adjacent teeth and/or bone
- * Change in the bite
- * Truisms (Jaw pain or difficulty opening mouth)
- * Failure of the treatment to its purpose
- * Dry socket
- * Swallowing of object
- * Fracture or breakage of jaw
- * Further surgery or treatment
- * Blindness (Partial or complete in both eyes)
- * Cheek, tongue, floor of the mouth or other tissue damage from instruments

State law also requires that I specifically advise you that, although very rare, death, brain damage, quadriplegia, paraplegia, loss of organ(s), loss of function of an organ(s), loss of function of face, arm(s), or leg(s), and disfiguring scars could occur.

Parent or Patient's Signature

Date

Last Complete Dental Exam _____

Last Full Mouth X-Rays _____

How Often Do You Brush Your Teeth Daily? _____

Please Answer Yes or No to the Following Questions:

- | YES | NO | |
|-----|-----|---|
| () | () | Are you having any dental problems at this time? If Yes, What? _____ |
| () | () | Is your present dental health poor? |
| () | () | Do you wear dentures? (Partials or Full) Are you unhappy with your dentures? |
| () | () | Would you like to know more about permanent replacements (Implants) ? |
| () | () | Have you had any periodontal (gum) treatments? |
| () | () | Have you had bad dental experiences in the past? |
| () | () | Are you apprehensive about dental treatments? |
| () | () | Do your gums bleed or feel tender or irritated? |
| () | () | Do you have loose, tipped, or shifting teeth? (Circle all that apply) |
| () | () | Do you have problems with food impaction? |
| () | () | Do you regularly use dental floss? |
| () | () | Are your teeth sensitive to hot, cold, sweets, or pressure? (Circle all that apply) |
| () | () | Are you unhappy with the appearance of your teeth? |
| () | () | Do you have discolored teeth that bother you? |
| () | () | Would you like your smile to look better or different ? |
| () | () | Have you worn braces on your teeth? Are you presently wearing a retainer? |
| () | () | Are you aware of grinding or clenching of your teeth? |
| () | () | Do you have headaches, earaches, or neck pains? (Circle all that apply) |
| () | () | Do you have problems with teeth/fillings breaking? |
| () | () | Do you have swelling or lumps in your mouth? |
| () | () | Do you have unusual sounds or pain in you ear while eating? |
| () | () | Do you have bad breath or unpleasant taste? |
| () | () | Do you have complications following extractions? |
| () | () | Do you smoke cigarettes, pipe, or cigar? |
| () | () | Do you use smokeless tobacco? |
| () | () | Do you use fluoride supplements; other than toothpaste? |
| () | () | Do you have difficulty chewing?) Does chewing cause pain? |
| () | () | Does opening wide cause pain?) Does your jaw ever lock? |
| () | () | Does your jaw pop or click? |
| () | () | Have you ever been told you have a TMJ problem? |
| () | () | Are you now, or have you ever been treated for TMJ problems? |
| () | () | Type Treatment: (Circle) Splint Bite Adjustment Restorative Procedures Surgical |

Is there any other dental information you feel I should be aware of ? _____

CONSENT FOR TREATMENT

A requirement facing all practitioners providing dental care is that the patient or legal representatives of the patient give the practitioner informed consent. Informed consent indicates your awareness of the possible risks involved in dental procedures, for there are risks involved in all procedures done for the human body, both medical and dental. For instance, it is possible that doing fillings and crowns on teeth can cause the tooth to become sensitive, requiring root canal therapy or extraction. Some teeth that seem to be successfully restored still may abscess later with the above mentioned complications. This is due to the fact that not all people respond the same way to generally accepted procedures, some of which may be due to, but not limited to, unsuspected allergies, etc. For this reason, we will provide informed consent forms prior to certain dental procedures. You have my assurance that even though informed consent is a legal requirement of all practitioners of medicine and dentistry, I will endeavor to keep these possible negative occurrences of dental treatment to a minimum.

I do hereby authorize Dr. James A. Presley/ Dr. Hilary G. Craddock to administer local anesthetics and provide dental treatment as may be necessary for the patient named above. I also understand that I am free to ask any questions regarding procedures and possible risks involved.

I understand that this office requires 48 hours notice to reschedule an appointment and charges \$75.00 for patient no shows.

Parent or Patient's Signature _____ Date _____

Richland Dental Group

Insurance Information

Dental Insurance (Primary)

Insured's Name _____
Insured's Birthday _____
Insured's SS# _____
Insurance Co. Name _____
Address _____
Policy # _____
Type of Coverage: Self Family

Dental Insurance (Secondary)

Insured's Name _____
Insured's Birthday _____
Insured's SS# _____
Insurance Co. Name _____
Address _____
Policy # _____
Type of Coverage: Self Family

Payment is due at time of service unless prior arrangements have been made.

I hereby authorize payment directly to Richland Dental Group. I understand that I am responsible for all cost of dental treatment. If I do not pay the entire balance within 25 days of the monthly billing date, a finance charge will be added to the account for the current billing period. In the case of default of payment, I promise to pay any legal cost together with any collection cost incurred in order to collect my balance. I hereby authorize Richland Dental Group to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right to Richland Dental Group to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

The information on this page and the dental medical histories are correct to the best of my knowledge.

Patient or Parent signature _____ Date _____

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