WELCOME

We at harmony dental care would like to welcome you to our office. We hope you are comforted to know that our office strives to meet your dental needs at a high level. Our website should allow you to familiarize yourself with our office. We take great pride in how we care for our patients and the quality of our work.

We would appreciate you completing the patient information forms and bringing them with you the day of your appointment or faxing them to 601-713-1393. If you have dental insurance, we encourage you to fax these forms prior to your appointment. Please let us know if you need an antibiotic prophylaxis before treatment.

We have a mission at Harmony Dental Care and that is to make you feel at home. We hope we have conveyed the sense of pride we have for our work. We are pleased that you have chosen us and look forward to meeting you.

Sincerely,

Dr. Kalil Abide and Staff

HARMONY DENTAL CARE

Date _____

PATIENT INFORMATION

Name _____ Home Phone _____

Soc. Sec # _____ Birth date _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

E-Mail Address _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City/State _____

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Soc. Sec. # _____ Birth date _____

Employer _____ Work Phone _____

Is This Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is due at each appointment.

☐ Cash ☐ Personal Check ☐ Visa ☐ Master Card

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth date _____ Social Security # _____ Work Phone _____

Name of Employer _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Group # _____ Policy ID # _____

HARMONY DENTAL CARE HEALTH HISTORY

DENTAL HISTORY

How long since you have seen a dentist? _____
Last COMPLETE Dental Exam, Date: _____ Last Full Mouth X-Rays, Date: _____
Are you having problems now? Yes No What? _____
Previous Dentist: _____

MEDICAL HISTORY

Do you have any CURRENT health problems? Yes No
Are you under a physician's care now? Yes No
For What? _____
What MEDICATIONS are you currently taking? _____
_____
Have you ever taken Phen-Fen/Redux? Yes No
Do you SMOKE? Yes No Use SMOKELESS Tobacco? Yes No
WOMEN ONLY:
Are you pregnant or think you may be pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

Family Physician _____.

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Mitral Valve Prolapse
Artificial heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joints (Hip, Knee)

Anemia
Stroke
Kidney Trouble
Ulcers
AIDS / HIV +
Hepatitis A (infectious)
Hepatitis B (serum)
Liver Disease
Blood Transfusion
Drug Addiction
Hemophilia
Fever Blisters
Epilepsy or Seizures

Nervousness
Psychiatric Treatment
Glaucoma
Chemotherapy (Cancer, Leukemia)
Tumors
Radiation Treatment
Venereal Disease (Syphilis, Gonorrhea, etc.)
Bruise Easily
Emphysema
Tuberculosis (TB)

Asthma
Sinus Trouble
Allergies or Hives
Diabetes
Hypoglycemia
Thyroid Disease
Arthritis
Cortisone Medicine
Pain in Jaw Joints
Eating Disorders
Alcoholism
Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex Rubber Nitrous Oxide Codeine
Penicillin Any Metals (eg. Nickel, mercury, etc)

Are you aware of being allergic to any other medications or substances?
If yes, please list: _____
Is there any other Medical or Dental information that you feel I should know about?
_____

CONSENT: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

Signature _____ Date: _____

Doctors Initials _____