

Parkway Dental of Clinton

Matthew K. Chow, D.D.S.

401 Clinton Parkway, Clinton, MS 39056

Patient Information:

Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth date: ____/____/____ Gender: _____ Family Status: _____

Address: _____ City/State/Zip: _____

Phone (Home): _____ (Cell): _____ (Other): _____

Employer Name: _____ Work Phone: _____

Employer's Address: _____ City/State/Zip: _____

If Minor (under 18) Name of Parent or Legal Guardian: _____

Person to contact in Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Responsible Party:

(If someone other than yourself is responsible for this account, please complete the following):

Name of person responsible for this account: _____ Relationship: _____

Address: _____ Home Phone: _____

Employer: _____ Work Phone: _____ SS#: _____

Insurance Information:

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ Insured's relationship to patient: _____

Insured's Address: _____ City/State/Zip: _____

Insured's Employer Name & Address: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Insurance Co. Address: _____ City/State/Zip: _____

* Do You Have Any Additional Dental Insurance? Yes No

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____			28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol / recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy / sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	57. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	58. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA (1-6)



DENTAL HISTORY

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



- | | | |
|---|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE



- | | | |
|---|--------------------------|--------------------------|
| 7. Do your gums bleed or are they painful when brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you experienced a burning sensation in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE



- | | | |
|--|--------------------------|--------------------------|
| 14. Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have grooves or notches on your teeth near the gum line? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT



- | | | |
|--|--------------------------|--------------------------|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you place your tongue between your teeth or rest your teeth against your tongue? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you clench your teeth in the daytime or make them sore? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS



- | | | |
|---|--------------------------|--------------------------|
| 33. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever whitened (bleached) your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you been disappointed with the appearance of previous dental work? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Financial Policy:

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of the patient must be determined before treatment.
- It is customary to receive payment in full for services rendered at the time of the first visit. The office accepts assignment on dental insurance so long as insurance benefits are verified and the deductible or co-payment is paid at the time of the visit.
- First time patients being treated on an emergency basis must pay in full at the time of service.
- The office will accept cash, personal checks, Visa, and MasterCard for all services rendered. A service charge of \$20.00 will be assessed on all returned checks.
- Third party financing is available through Care Credit Financial. Please see the office manager for details.
- The office will gladly accept dental insurance. Patients are responsible for the full amount. The office manager will estimate the benefits for services rendered, with any deductible and co-payment due at the time of service. The estimated co-payment is due on the day service is rendered. Remember that these are estimates only. Patients will be responsible for the difference between the actual payment and the fee. Patients should understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination. **If payment has not been received from the insurance company within sixty days of the original filing, then the patient will be asked to pay balance due and pursue reimbursement from their insurance carrier.**
- The office will assess account balances in excess of 60 days a monthly service charge of one half percent (1.5% per month) of the unpaid balance. **The office requires the patient to give at least 24-hour notice of any appointment that needs to be rescheduled or cancelled. We will allow you to reschedule a second appointment, if your first appointment was broken. If the second appointment is also broken, we will then charge a failed appointment fee of \$25.00 and in order to receive another appointment we will require the patient portion of the service at the time the appointment is made.**

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment. I understand and agree to abide by the financial policy, and authorize payment directly to Dr. Matthew K. Chow of the insurance benefits otherwise payable to me.

_____/_____/_____
Signature or Patient (Parent or Guardian if a minor) Date Relationship to Patient

_____/_____/_____
Signature of guarantor of payment/responsible party Date Relationship to Patient

We invite you to discuss with us any question regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient

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Matthew K. Chow, D.D.S.
401 Clinton Parkway, Clinton, MS 39056

***ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES***

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this acknowledgment

By signing

I acknowledge that I have received a copy of the Dental Health Professional's Notice of Privacy Practices.

Please Print Name

Signature

Date

Please list the names of your family members who are patients of our practice:
