

JACKSON DENTAL PROFESSIONALS

PATIENT INFORMATION

DATE: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Social Security No.: \_\_\_\_\_
E-Mail: \_\_\_\_\_ I would like to receive correspondence via E-Mail  Yes  No
Employment Status:  Full Time  Part Time  Retired  None
Student Status:  Full Time  Part Time
If Full Time, Name of School: \_\_\_\_\_ City/State of School: \_\_\_\_\_
How did you hear about us? \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Child  Other
Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_
Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ ID No. \_\_\_\_\_
Insurance Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Insurance Co. Phone No.: \_\_\_\_\_

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Child  Other
Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_
Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ ID No. \_\_\_\_\_
Insurance Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Insurance Co. Phone No.: \_\_\_\_\_

FULL TIME COLLEGE STUDENTS MUST SEND PROOF OF STUDENT STATUS TO INSURANCE COMPANY EVERY SEMESTER

TO OUR PATIENTS: Although dentists primarily treat the area of the mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you are taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. ALL ANSWERS ARE KEPT CONFIDENTIAL.

What brought you to our office today? \_\_\_\_\_
Is there anything else you wanted done or looked at today? \_\_\_\_\_
When did you last visit a dentist? \_\_\_\_\_ If child, is this your first visit? \_\_\_\_\_
What was done during your last visit? \_\_\_\_\_
Previous Dentist: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_
Are you satisfied with the appearance of your teeth?  Yes  No
Are you interested in whitening your teeth?  Yes  No
If you have not had regular dental treatment, what is the reason? \_\_\_\_\_
Do you have or ever had any of the following:
 Bleeding Gums  Difficulty Chewing  Sensitivity to:  Hot  Cold  Sweets
 Facial Pain  Abscesses  Unpleasant Odor  Broken Fillings
 Ulcers/Sores/Boils  Ear Pain  Abnormal Growths

## MEDICAL HISTORY

Are you currently under the care of a physician?  Yes  No If yes, for what condition? \_\_\_\_\_  
Have you ever been hospitalized or had major surgery?  Yes  No If yes, for what condition? \_\_\_\_\_  
Have you ever had a serious head or neck injury?  Yes  No If yes, for what condition? \_\_\_\_\_  
Please list all the medications you are taking: \_\_\_\_\_  
Do you use tobacco? If yes, how much? \_\_\_\_\_  
Are you on a special diet? If yes, what kind? \_\_\_\_\_

WOMEN: Are you pregnant?  Yes  No Trying to get pregnant?  Yes  No Nursing?  Yes  No  
Are you taking contraceptives?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Latex  Metal  Local Anesthetics  Other: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Phone No.: \_\_\_\_\_

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Rheumatic Fever**
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Herpes	<input type="checkbox"/> Shingles
<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Artificial Heart Valve**	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hormone Treatment	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Joint**	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Leukemia	<input type="checkbox"/> TMJ/Pain in Jaw
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mitral Valve Prolapse**	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Parathyroid Disease	
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur**	<input type="checkbox"/> Prostate Problem	
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Pace Maker**	<input type="checkbox"/> Psychiatric Care	
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Radiation Therapy	

\*\* These conditions may require medication.

Have you had any of the following surgically place:  Pins  Screws  Rods  Plates  Implants  Other  
If you answer yes to any of the above, when were they placed? \_\_\_\_\_

Please list any condition not mentioned above: \_\_\_\_\_

Primary Medical Doctor: Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Cardiologist: Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Orthopedic Surgeon: Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Oncologist: Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Other: \_\_\_\_\_

IF YOU MUST CANCEL YOUR APPOINTMENT WE URGE YOU TO GIVE US AT LEAST 24 HOURS NOTICE SO THAT PATIENTS ON OUR WAITING LIST CAN BE SCHEDULED IN YOUR PLACE. FAILURE TO GIVE US 48 HOURS NOTICE COULD RESULT IN A BROKEN APPOINTMENT CHARGE. PLEASE INITIAL \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

PATIENT FINANCIAL AND INSURANCE BENEFITS AGREEMENT  
FOR THE OFFICE OF JACKSON DENTAL PROFESSIONALS

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate excellent service to you while minimizing our administrative costs.

We require you to sign this agreement and/or any necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office. Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and facilitate payment to our office. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time.

**All charges you incur are your responsibility regardless your of insurance coverage.** We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to the contract. If payment from your insurance company is not received within 60 days from the date of service, you will be expected to pay the balance in full immediately.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to sort out any questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any dispute over payments made or not made by your insurance company.

**Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time we provide the service to you.** The co-payment is only an estimate and may be found to be insufficient after review by your insurance company. Our office accepts cash, personal checks, MasterCard, and Visa. Additional financing is available through Wells Fargo Financial upon request and approval.

Returned checks and balances older than 30 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

**I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.**

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT/RESPONSIBLE PARTY