

PATIENT INFORMATION _____

Date _____ Home Telephone _____ Office Telephone _____
Cell Phone _____

PERSONAL INFORMATION

Name _____
Address _____
City _____ Zip _____
E-Mail _____
Birthdate _____ Age _____
Employer _____
Business Address _____
City _____ Zip _____
Social Security # _____
Driver's License# _____

SPOUSE/PARENT INFORMATION

Name _____
Employer _____
Business Address _____
City _____ Zip _____
Business Phone _____ Ext _____
Position _____
Social Security # _____
Birth Date _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

GENERAL INFORMATION

Convenient appointment time _____
Are you available for appointments on short notice? _____
Person to contact for emergency _____
Relationship to patient _____
Their telephone _____

If you have dental insurance, please fill in the following:

PRIMARY CARRIER

Name of Insured _____
Social Security # _____
Employer _____
Insurance Carrier Name _____
Insurance Carrier Address _____
Member # _____
Date employed _____

* We file insurance claims as a courtesy to our patients. Ultimately, any disagreements for non-payment of claims are between the patient and insurance company. While we make every effort to collect insurance benefits, the patient remains responsible for any remaining balance.

MEDICAL HISTORY

Please answer EACH question

1. Do you have, or have you had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting Spells or Seizures |
| <input type="checkbox"/> Heart Ailments | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease | <input type="checkbox"/> Rheumatism or Arthritis |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Radiation Treatment of Any Kind | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Do you use tobacco products? | | <input type="checkbox"/> Artificial Prosthesis |

1. Are you in good health? Yes No
2. Date of last medical exam _____
3. Have you ever been hospitalized? Yes No
If so, what was the problem? _____
4. Are you taking any drugs or medication? Yes No
If so, what? _____
5. Do you have any disease, problem or condition you think I should know about? _____
6. Do you think you have been in contact with the AIDS virus? Yes No
7. Have you been told that you need antibiotics before dental treatment? Yes No
8. Are you pregnant? Yes No

9. Are you sensitive or allergic to any drugs? Yes No
If so, please list _____
10. Do you wear a cardiac pacemaker? Yes No
11. Have you had heart surgery? Yes No
12. Are you now under care of M.D.? Yes No
13. Have you had any serious illness? Yes No
14. Blood Pressure, if known _____

Physician's name _____
Address _____ Phone _____

DENTAL HISTORY

1. How long since you've been to a dentist? _____
2. Reason for visit today? _____
3. How often do you floss your teeth? _____
4. Have you ever been treated for periodontal disease? Yes No
5. Have you ever had any complications from an extraction? Yes No

6. Have you ever had a popping or clicking near your ear when you chew? Yes No
7. Are you prone to frequent headaches? Yes No
8. Do you grind your teeth? Yes No
9. Do your gums bleed when you brush? Yes No
10. Do you have sores, blisters or swelling on your gums, lips or cheeks? Yes No
11. Have you ever had orthodontic treatment? Yes No
12. Are you happy with your smile? Yes No

If yes, explain _____

Previous Dentist _____ City _____ Phone () _____

REMARKS

IS THERE ANY ADDITIONAL MEDICAL OR DENTAL INFORMATION WE MAY NEED TO KNOW BEFORE BEGINNING TREATMENT?

CONSENT

Minor: I, being the parent (or guardian) of the above named minor patient do hereby authorize the performance of dental services upon this patient and whatever procedures that the judgement of the doctor may dictate in order to carry out treatment procedures as outlined on the treatment plan form. I also authorize and request the administration of such anesthetics and/or sedatives as may be deemed advisably by the doctor.

Adult: I hereby consent to the treatment indicated on my examination form, including the use of the anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Relative _____ Date _____ Date _____

Signature _____ Signature _____

Jackson Dental

Office Policies:

So that the office can better serve you, we request that you please read and understand our office policies. If you have any questions, please feel free to ask the office staff.

BROKEN APPOINTMENTS:

Please understand that appointment time in any dental office is limited and valuable. Therefore it is important that all patients honor their reserved appointment time. Failure to do so deprives other patients from receiving needed dental care in a timely fashion.

So that our office will not be penalized by those who fail to keep their appointments, we reserve the right to charge **\$50.00 per hour** for broken appointments. This fee will not be charged if we receive **24 hours notice** prior to your scheduled appointment time. The patient is responsible for the charge and it is to be paid prior to the scheduling of any new appointment. After 2 broken appointments we reserve the right to sever the Doctor/Patient relationship and discontinue treatment.

FEES AND FINANCIAL ARRANGEMENTS:

We offer several different payment options including financing through Dental Fee Plan, all major charge cards including VISA, Mastercard and American Express and checks and cash of course. We do not offer in house financing and do not carry balances.

ACCOUNTS WITH DENTAL INSURANCE:

Any new patient with insurance must bring in a completed insurance form or insurance card. We do file primary insurance claims as a courtesy to our patients. We do not file secondary claims. The insurance relationship is between you and your insurance company. The patient is always responsible for his or her portion at the time of service. After 45 days, the total amount becomes the responsibility of the patient or the guarantor. Unless arrangements are made with the office, the account will then be susceptible for collection agency status. All collection cost and attorney fees will be the responsibility of the patient.

Thank you for your understanding. These policies are in place to insure strong communication between our office and you! We appreciate you and look forward to serving your dental needs!

Sincerely,

Susan Jackson, Office Manager

Acknowledgement: _____ date: _____

Jackson **Dental**

Broken Appointment Policy

Please understand that appointment time in any dental office is limited and valuable.

Therefore it is important that all patients honor their reserved appointment time. Failure to do so deprives other patients from receiving dental care in a timely fashion.

So that the dentist, our staff, and our other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates the right to charge \$50.00 an hour for broken appointments. The fee will not be charged if we receive 24 hours notice prior to your scheduled appointment time. The balance must be paid before rescheduling the appointment.

Signature _____

Date _____

Patient Name _____

(Please Print)

ROBERT E. JACKSON, D.D.S.

1012 W. Hebron Pkwy • Suite 108 • Carrollton, TX 75010

Telephone: 972.492.1064

SIGNATURE ON FILE

- I authorize use of this form on **all** my insurance submissions.
- I authorize release of information to all my **Insurance Companies**.
- I understand that **I am responsible** for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance Companies.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- My signature also applies to the dependents listed on the back of this card.

Signature _____

Date _____

NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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