

Name: _____

Insurance Information

Primary

Name of Insured: _____ Relationship to Patient _____

SS# _____ Insured's DOB: _____

Insurance Company (Name & Address) _____

Insurance Phone: _____ Fax _____

Insurance Group # _____ Policy ID/# _____ Effective Date _____

Cancellation Policy

We ask that at least 24 hours advanced notice for canceling or rescheduling an appointment; otherwise, a **\$65 fee** may be assessed to your account.

Note: All cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people – the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

Signature _____ Date _____

Acknowledgement & Release

Insurance:

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however, the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company; therefore we do not confirm insurance eligibility or predetermine recommended treatment.

Collections:

In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

Signature _____ Date _____

Patient Medical History

- | | | | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No | | Yes | No |
| 1. Are you under medical treatment now?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?
If yes, what medication(s) are you taking?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you need to pre-medicate?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances?..... | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you allergic to or have you had any reactions to the following? | | | | | | | | |
| Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. Novacaine) | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
8. Women Only:
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| a) Are you pregnant or think you may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are you taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |

9. Do you have or have you had any of the following?
- | | | | | | | | | |
|-----------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No | | Yes | No |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Frequently tired | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Aids/HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement/Implant | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have (please check) <input type="checkbox"/> dentures, <input type="checkbox"/> partials and/or <input type="checkbox"/> implants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you had oral hygiene instructions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced clicking, pain, and/or difficulty in opening and/or closing in relation to your jaw? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you had any periodontal treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

CONSENT:

1. I _____ hereby authorize D. Jefferies and/or staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine. As stated in the "Payment Policy" form, payment is due and payable at the time services are rendered unless other arrangements have been made. (See form for additional information).
4. I understand that a \$65 fee will be assessed for any missed appointments. Should I need to cancel or change any appointments, I understand that I need to give the office 24 hours notice
5. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

Patient _____ Date _____ Witness _____
 Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date _____

Release of Information Consent Form

I _____, have read and understood the HIPAA Notice of Privacy Practices that was provided to me by Dr. Jefferies. However, In the event that I may need them to do so, I grant permission for Dr. Jefferies and or staff to: **(Please Check one of the following):**

- 1- Discuss any aspect of my treatment and or needs with my:
 - Spouse _____ (initial)
 - Parent (if patient is over 18) _____ (initial)
 - Other _____ (initial)
(Name)

- 2- Have the above designated person, pick up any dental appliances, x-rays or dental records on my behalf. _____ (initial)

- 3- I do not wish to have my information discussed with anyone outside of the parameters of Health Insurance Portability and Accountability Act of 1996.

Patient – Signature

Date

Doctor – Signature

Date