JAMESTOWNE DENTAL

PATIENT INFORMATION(CONFIDENTIAL)

Date:_____

SSN:_____

Name:_____ Preferred Name: _____ Birthdate:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Cell phone:_____

Home phone:_____ Work phone:_____

Can we send: email reminders? ☐ Yes ☐ No **text reminders?** ☐ Yes ☐ No

Relationship Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact:_____ Phone #:_____ Relationship:_____

RESPONSIBLE PARTY

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

Birthdate:_____ SSN:_____ cell phone:_____ home phone:_____

Is this person currently a patient in our office? ☐ Yes ☐ No

Address:_____ City:_____ State:_____ Zip:_____

INSURANCE INFORMATION

Name of subscriber:_____ Relationship to patient:_____

Birthdate:_____ SSN:_____ Phone #:_____

Name of Employer: _____ Work Phone #_____

Name of Insurance Company:_____ Group #_____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ **YES** ☐ **NO IF YES, PLEASE COMPLETE THE FOLLOWING:**

Name of subscriber:_____ Relationship to patient:_____

Birthdate:_____ SSN:_____ Phone #:_____

Name of Employer: _____ Work Phone #_____

Name of Insurance Company:_____ Group #_____

MEDICAL HISTORY

Patient Name:_____ **Birthdate:**_____

Please Circle your answers to the following questions:

Are you under a physician's care now? Yes No If yes, please explain:

_____

Have you been hospitalized or had a major operation? Yes No If yes, please explain:

_____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain or provide a medication list:_____

_____

_____

Do you take or have you taken Phen-Fen or Redux? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Do you have an artificial heart valve or joint? Yes No If yes, please explain and provide surgeon information:_____

Do you use tobacco (including smokeless or betel nut products)? Yes No

Do you used controlled substances? Yes No

Have you ever been advised to take medication prior to dental treatment? Yes No

Women: Are You Pregnant/Trying to get pregnant? Yes No If yes, Due Date ___/___/___

OBGYN:_____ **Phone #:**_____

Taking Oral Contraceptive? Yes No Nursing? Yes No

Are you allergic to any of the following? ☐ **Red Dye** ☐ **Nuts**

☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Local Anesthetic** ☐ **Acrylic** ☐ **Metal**

☐ **Latex** ☐ **Sulfa Drugs** ☐ **Other, please explain:**_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Emphysema	Yes	No	Hives or Rash	Yes	No	Thyroid Disease	Yes	No
Alzheimer's Disease	Yes	No	Epilepsy/Seizures	Yes	No	Kidney Problems	Yes	No	Tuberculosis	Yes	No
Anemia	Yes	No	Excessive Bleeding	Yes	No	Liver Disease	Yes	No	Tumor or Growth	Yes	No
Arthritis/Gout	Yes	No	Fainting Spells/Dizziness	Yes	No	Low Blood Pressure	Yes	No	Ulcers	Yes	No
Asthma	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Other: _____		
Blood Disease	Yes	No	Hemophilia/Bruise Easy	Yes	No	Osteoporosis	Yes	No			
Blood Transfusion	Yes	No	Heart Attack/Failure	Yes	No	Pain In Jaw Joints	Yes	No	_____		
Breathing Problem	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No			
Cancer	Yes	No	Heart Pacemaker	Yes	No	Radiation Treatment	Yes	No	_____		
Chemotherapy/Radiation	Yes	No	Heart Trouble/Disease	Yes	No	Rheumatic Fever	Yes	No			
Chest Pains(Angina)	Yes	No	Heart Surgery	Yes	No	Scarlet Fever	Yes	No			
Cold Sores/Fever Blisters	Yes	No	Hepatitis A	Yes	No	Sickle Cell Disease	Yes	No			
Congenital Heart Disorder	Yes	No	Hepatitis B or C	Yes	No	Sinus Trouble	Yes	No			
Cortisone Medicine	Yes	No	Herpes	Yes	No	STD(venereal disease)	Yes	No			
Diabetes	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No			
Drug Addiction	Yes	No	High Cholesterol	Yes	No	Swelling of Limbs	Yes	No			

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, GUARDIAN: _____ DATE:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices (displayed in our waiting room) or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, _____, have read the displayed copy of this office's Notice of Privacy Practices. I understand that I can request a hard copy for my records.

_____

Please Print Name

_____ _____

Signature Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____

Please Print Name Relationship

_____ _____

Please Print Name Relationship

On the occasion I am referred to another office or information is needed from my physician's office, I also give Jamestowne Dental permission to release/obtain the following:

☐ **x-rays** ☐ **dental/medical records** ☐ **insurance information** ☐ **nothing is to be released/obtained**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communication barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other:**

_____

_____

_____ _____

Office Personnel **Date**

Jamestowne Dental Financial Policy

Please Read the Following Carefully

Print name of Head of Household and all patients on account:

_____

_____

Insurance/Self-Pay

If you have dental insurance, we will estimate your benefits to the best of our ability. However, we work with over 1,500 insurance companies annually. For this reason, we leave it up to the insurance subscriber to be responsible to know your insurance benefits, exclusions, and policy details. We have a computerized system that allows us to put limited information about your policy in your file, which enables us to estimate the co-payments, etc. for your appointments. We do not take responsibility if an insurance company does not pay for treatment as originally expected or as we quoted you. If proper determination of your benefits is made by us at or before your appointment, we will accept assignment of benefits for the insurance portion only. **All co-payments, deductibles, and fees for non-covered services are due at the time of service.** If no dental insurance is available, **all fees are due at the time of service.** These fees will be discussed to the best of our ability before treatment is rendered. We accept Cash, Check, Discover, MasterCard, Visa, and Care Credit.

Signature:_____Date:_____

Insurance Authorization

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of any pertinent information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance forms, whether manual or electronic.

Signature:_____Date:_____

Financial Agreement/Appointments

I give my consent for my appointments to be confirmed via voicemail, answering machine message, and or post card. If I prefer to receive text message or email confirmations I will select so on my patient information form. **There is a $50 charge for any appointment that is missed or cancelled without 48-hours notice. I understand this fee is not covered by my insurance and is my responsibility.** I understand that present and future treatment can be terminated due to missed appointments. I understand that three missed appointments will result in dismissal from Jamestowne Dental or the availability to schedule same day only.

I understand the policies outlined above and accept them. In the event that my account is not paid, I agree to pay all costs of collection, including but not limited to reasonable attorney's fees, collection fees, court costs, billing charges, and/or interest charges. There will be a $5.00 billing charge or a 2% monthly interest charge on all account balances over 30 days.

Signature:_____Date_____

Patient Survey

Are you currently having any of the following (please circle):

Pain
Swelling
Hot/Cold Sensitivity
Bleeding Gums
Popping/Clicking of Jaw
Sores

Do you like your Smile? Yes No If No, please explain_____

_____

_____

How many times a day are you brushing? _____ flossing? _____

Have you ever had problems with previous dental care? Yes No

If Yes, please explain_____

_____

Name of previous Dentist? _____

When was your last dental visit? _____

Do you currently wear Dentures/Partials? Yes No

Do you feel any of the following could be a barrier for you when needing to complete treatment?

Fear
Finances
Time

How did you hear about our office?_____

_____