Welcome To Our Practice

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Today's Date _____ Birth Date _____ Patient Social Security # _____

Patient Name _____
(Last Name) (First Name) (Initial)

Street Address _____

City _____ State _____ Zip _____

Occupation _____ ❒ Male ❒ Female ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Separated

Patient Home Phone _____ Patient Work Phone _____

Employer _____ Employer Phone _____

Employer Address _____

In Case Of Emergency Contact:

Name _____ Relationship _____

Emergency Home Phone _____ Emergency Work Phone _____

Whom may we thank for refering you to us? _____

PRIMARY INSURANCE

Individual responsible for this account _____
(Last Name) (First Name) (Initial)

Relationship to Patient _____ Birth Date _____ Social Security # _____

Street Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Individual's Name _____
(Last Name) (First Name) (Initial)

Relationship to Patient _____ Birth Date _____ Social Security # _____

Street Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Party Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arangements have been approved.

FAMILY HEALTH INFORMATION

Some health conditions are the result of hereditary weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents and grandparents) will give us a better understanding of your health needs.

RELATIONSHIP TO YOU	FAMILY MEMBER PRESENT AND PAST HEALTH PROBLEMS

MEDICATIONS

List medications you are currently taking:

Pharmacy _____ Phone _____

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other (please list)

_____

_____

_____

CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

- ❑ AIDS
- ❑ Appendicitis
- ❑ Arm Pain or Numbness
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain or Numbness
- ❑ Bleeding Disorders
- ❑ Bleeding Gums
- ❑ Bloating
- ❑ Blood in Urine
- ❑ Blurred Vision
- ❑ Bowel Changes
- ❑ Breast Lump
- ❑ Brights Disease
- ❑ Bruise Easily
- ❑ Bursitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Change in Moles
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Chills
- ❑ Constipation
- ❑ Crossed Eyes
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Depression/Nervousness
- ❑ Difficulty Swallowing
- ❑ Dizziness/Fainting
- ❑ Double Vision
- ❑ Excessive Thirst
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Earache
- ❑ Ear Discharge
- ❑ Feet Pain or Numbness
- ❑ Fever
- ❑ Forgetfulness
- ❑ Frequent Urination
- ❑ Gas
- ❑ Glaucoma
- ❑ Hand Pain or Numbness
- ❑ Hay Fever
- ❑ Headache
- ❑ Heart Disease
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hip Pain or Numbness
- ❑ HIV Positive
- ❑ Hives
- ❑ Hoarseness
- ❑ Indigestion
- ❑ Irregular Heartbeat
- ❑ Itching
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Lack of Bladder Control
- ❑ Leg Pain or Numbness
- ❑ Liver Disease
- ❑ Loss of Hearing
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Low Blood Pressure
- ❑ Lumbago
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nausea
- ❑ Neck Pain or Numbness
- ❑ Neuralgia
- ❑ Neuritis
- ❑ Nose Bleeds
- ❑ Pacemaker
- ❑ Painful Urination
- ❑ Persistent Cough
- ❑ Pneumonia
- ❑ Polio
- ❑ Poor Appetite
- ❑ Poor Circulation
- ❑ Prostate Problem
- ❑ Rapid Heartbeat
- ❑ Rash
- ❑ Rectal Bleeding
- ❑ Rheumatic Fever
- ❑ Ringing in Ears
- ❑ Scarlet Fever
- ❑ Scars
- ❑ Sciatica
- ❑ Shoulder Pain or Numbness
- ❑ Sinus Problems
- ❑ Sore That Won't Heal
- ❑ Stomach Aches or Pains
- ❑ Stroke
- ❑ Sweats
- ❑ Swelling Ankles
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Vision Flashes
- ❑ Vomiting
- ❑ Vomiting Blood

CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE
Alcohol	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑
Coffee	❑	❑	❑	❑

	HEAVY	CASUAL	LIGHT	NONE
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sleep	❑	❑	❑	❑

	HEAVY	CASUAL	LIGHT	NONE
Soft Drinks	❑	❑	❑	❑
Sugar/Sugar Products	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Water	❑	❑	❑	❑

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ 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 then 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