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

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I _____ ,have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

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**

[] **Communications barriers prohibited obtaining the acknowledgement**

[] **An emergency situation prevented us from obtaining acknowledgement**

[] **Other { Please Specify}**

_____

_____

_____

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 _____