Patient's Name:_____ Preferred Name:_____
(Last) (First) (MI)
Status: Married Single Minor Gender: Male Female

Date of Birth:_____ Social Security # _____ Parent/Guardian (If Minor)_____

Address:_____
(Street) (City) (State) (Zip)

Home #:_____ Cell #:_____ Work #:_____ Employer:_____

Email:_____
Emergency Contact:_____ Preferred appointment time: Morning Afternoon
Relationship: Parent Spouse Family Friend Other Preferred appointment day: M W T Th
Phone #:_____

Primary Dental Information

Insurance Co._____
Insurance phone #_____
Employer: _____
Group Number:_____
Subscriber ID or SS #_____
Subscriber Name:_____
Subscriber Date of Birth:_____

Secondary Dental Information

Insurance Co._____
Insurance phone #_____
Employer: _____
Group Number:_____
Subscriber ID or SS #_____
Subscriber Name:_____
Subscriber Date of Birth:_____

I authorize payment directly to **Roy D. Jennings, D.D.S.**, of insurance benefits otherwise payable to me. I understand that my dental insurance or carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

Patient / Guardian Signature:_____ Date:_____

To the best of my knowledge, all of the information provided above is true and correct.

_____ Date _____
Patient / Guardian Signature

Whom may we thank for referring you to our practice?

Yellow Pages Previous Patient Facebook
Internet Walk-In/Drive By Another Patient_____

MEDICAL HISTORY **Print Name:** _____ **Date**: _____

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

Please list all medications you are currently taking including vitamins or herbal supplements.
Please list: _____

Are you currently taking medication for osteoprosis or blood thinners? Yes _____

Please circle any of the following which you have at present or had in the past:

Artificial joints/prosthesis	Yes	Allergies/Hives	Yes	Stroke	Yes
Artificial heart valves	Yes	Asthma	Yes	Diabetes	Yes
Heart murmurs	Yes	Arthritis/Rheumatism	Yes	Cancer	Yes
Heart disease	Yes	Rheumatic fever	Yes	Chemotherapy	Yes
Pacemaker	Yes	Liver disease	Yes	Radiation treatment	Yes
Mitral Valve Prolapse	Yes	Tuberculosis	Yes	Epilepsy/Seizure	Yes
Heart Attack/Failure	Yes	Alzheimers Disease	Yes	Kidney problems	Yes
Bleed excessively	Yes	Dementia	Yes	Smoke/forms of tobacco	Yes
Hepatitis	Yes	Psychiatric care	Yes	Fainting/Dizzy Spells	Yes
AIDS/HIV	Yes	Emphysema	Yes	Ulcers	Yes
Latex/metal sensitivity	Yes	Anemia/Hemophilia	Yes	Cold sores/Fever Blisters	Yes
Drug addiction	Yes	Thyroid disease	Yes	Take Birth Control	Yes
High blood pressure	Yes	Low Blood Pressure	Yes	Could you be pregnant	Yes
				If Yes, Due Date:	_____

Are you allergic to any of the following:

Local Anesthetic	Yes	Sulfa Drugs:	Yes	Codeine Allergy	Yes
Penicillin Allergy	Yes	Asprin	Yes	Other:	_____

DENTAL HISTORY

Purpose of initial visit:	_____			Do you have a fear of dentists?	Yes	No
Date of last cleaning:	_____			Were x-rays taken?	Yes	No
Previous dentist name:	_____			Have you had orthodontic work?	Yes	No
How often do you brush your teeth?	_____			Do you grind your teeth?	Yes	No
How often do you floss your teeth?	_____			Does you jaw click or pop?	Yes	No
Are you happy with the appearance of your teeth?		Yes	No	Have you had gum surgery?	Yes	No
Have any teeth been removed?		Yes	No	Do your gums bleed or hurt?	Yes	No
Have any teeth been replaced?		Yes	No	If Yes, when?	_____	
Are you interested in permanent replacement?		Yes	No	Are your teeth sensitive to:		
Have you had soreness around your face or ear?		Yes	No	Hot Cold Sweets Pressure None		
Do you feel your breath is unpleasant at times?		Yes	No	Do you have any questions or concerns?		
Does food get caught in your teeth?		Yes	No	_____		

Have you had complications with dental treatment in the past? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any changes in my health, I will inform the doctors at my next appointment without fail.

_____ _____
Signature of Patient **Date**

Rev: 03/2016

CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre-and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

Do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment you signal your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

In the event that Roy D. Jennings, D.D.S. or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

_____ _____

Patient Signature **Date**

CONSENT TO LOCAL ANESTHESIA

I hereby authorize Roy D. Jennings D.D.S., to administer local anesthesia to me. I have been informed of the usual side effects and have been informed of the advantages and disadvantages of anesthesia. I understand the risk of reactions, such as redness, swelling, pain, itching, vomiting, anaphylactic shock and/ or permanent nerve damage or other unforeseeable complications which may result from the administration of anesthetics. I realize that in spite of the possible complications, the use of anesthesia is necessary and desired by me.

_____ _____

Patient Signature **Date**

OFFICE FINANCIAL POLICY

PATIENTS WITH INSURANCE

We will provide you with an *estimate* of the total fee expected. Your estimated portion is due in full the day of treatment. As a courtesy, we will file your insurance. **If after 40 days we have not received payment from your insurance company, the balance becomes your responsibility.** We will bill you and allow you 15 days to settle your account.

When estimating insurance coverage, we stress the word ***estimate*** as dental benefits are determined by each patient's dental contract. Insurance is a contract between **you** and **your insurance company**. We are not a party to that contract.

PAYMENT OPTIONS

We understand that it may be difficult to afford out-of-pocket care. For your convenience, we offer the following payment option:

- **Cash**
- **Check** ($30 charge for all returned checks)
- **Visa, Master Card, Discover**
- **Monthly Payments** (Short-term and long-term financing through **Care Credit** a dental payment plan with no interest plans for up to 12 months*)

CANCELLATION - 24-HOUR CANCELLATION POLICY

We recognize that unexpected things come up for all of us but, as a courtesy to our other patients and our staff, we require that you cancel any appointment with a **minimum of 24 hours notice**. Sufficient notice allows us to fill the open appointment time with another patient needing treatment. Leaving a message after hours on our voice mail does not allow us enough time to reschedule. Once a spot is reserved, IT IS YOUR SPOT!

Please note that we charge a $50.00 *late cancellation* or *no show* fee.

In addition, if something unforeseen arises and you are going to be **more than 15 minutes late for your appointment** we will consider this a late cancelation and ask that you reschedule your visit. We understand that people get delayed by circumstances beyond their control but one late patient can mean all subsequent patients scheduled that day are delayed.

Our goal is to be respectful of all our patients and their needs. We appreciate your cooperation with our policies.

_____ _____

Signature of Patient/Guardian **Date**

HIPAA OMNIBUS RULE

Patient Acknowledgement of receipt of notice of privacy practices and consent/limited authorization & release form.

You may refuse to sign this acknowledgement & authorization.

In refusing We MAY NOT BE ALLOWED TO PROCESS YOUR INSURANCE CLAIMS.

Please print your name:_____ **Date of Birth**:_____

The undersigned acknowledges receipt of a copy of the currently effective notice of privacy practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

I authorize contact from this office to Confirm my Appointment, Treatment, & Billing Information VIA:

- ☐ My personal voice mail
- ☐ Spouse/Parent
- ☐ Email confirmation
- ☐ Any of the above

Please list any other parties who can have access to your health information:
(This includes spouse, friend, care taker or family member ie; parent, step parent, child, or grandparent)

Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____ (Initial here) Acknowledge that **Roy D. Jennings, DDS** corresponds electronically and /or over the phone with referral doctors with health information.

In signing this HIPAA patient acknowledgement form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus rule, provide you this information with your knowledge and consent.

You may revoke this authorization in writing or by updating this form.

_____ _____
Patient Signature Date

_____ _____
Legal Representative Description of Authority