PATIENT INFORMATION

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as thoroughly as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Date _____ Home Phone ( )_____ Cell Phone( )_____

Name _____Soc Sec #_____
Last Name First Name Middle Initial

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F Age _____ Birthdate _____ Patient's E-mail Address_____

☐Married ☐Widowed ☐Single ☐Separated ☐Divorced ☐Partnered for Years ☐Minor

Patient Employer/ School Occupation _____ Whom may we thank for referring you?_____

In case of emergency, who should be notified? _____ Phone( )_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account:_____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc Sec #_____

Address (If different from Patient's) _____ Phone ( )_____

City _____State _____Zip _____

Person Responsible Employed By _____ Occupation _____Business Phone ( )_____

Insurance Company _____ Phone # _____ Group #_____ Subscriber #_____

Authorization for Submission of Claims, Assignments of Benefits, Release of Records, Financial and Appointment Policies

I authorize Jonesville Family Dentistry to submit claims for payment of services to the dental care service plans or insurance companies names below on my behalf in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services.

I authorize Jonesville Family Dentistry to release to hospital or care service plans, insurance companies, self-insurers, or their representatives, any and all info and records (including x-rays about my dental history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate claims for benefits. If my coverage is under a group master agreement held by my employer an associate trust fund, or union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization will remain effective for up to 5 years from this date. I know I have a right to receive a copy of this authorization if requested.

I understand that I am financially responsible for any changes NOT covered by the group insurance benefits. I have read and understand the office and financial polices.

Patient Name: _____

Insurance carrier (If applicable): _____

Signature of Patient or Guardian: _____Date: _____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study, models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____;s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
3. I agree to use the anesthetics, sedatives, and other medication as necessary. I fully understand that suing anesthetic agents embodies certain risks. I under that I can ask for complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account, I also understand a check of my history may be made.

Patient's Signature: _____ Date:_____

Parent/ Responsible Party's Signature: _____ Relationship to Patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

(You May Refuse to Sign This Acknowledgment)

I, _____, have had the opportunity to receive a copy of this office's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
Individual refused to sign
Communication barriers prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgment
Other: _____

Name _____
Last Name First Name Middle Initial

DENTAL HISTORY

Reason for Today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays_____

Former Dentist Address _____

Check (√) if you have had problems with any of the following:

□Bad breath □Bleeding gums □Clicking or popping jaw □Food collection between teeth □Grinding teeth
□Loose teeth or broken fillings □Periodontal treatment □Sensitivity to cold □Sensitivity to hot
□Sensitivity to sweets □Sensitivity when biting □Sores or growths in your mouth □Jaw Pain
How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's name _____ Date of Last Visit _____

Do you currently (or have you had in the past) taken Bisphosphonates (e.g. Boniva, Fosamax, Actonel)? □Yes □No

Have you had any serious illness or operations? □Yes □No If yes, describe _____

Have you ever had a blood transfusion? □Yes □No If yes, give approximate dates_____

(Women) Are you pregnant? □Yes □No *Nursing? □Yes □No *Taking Birth Control? □Yes □No

Check (√) if you have had problems with any of the following:

□ Anemia	□ Contact Lenses	□ Hepatitis	□ Rheumatic Fever
□ Arthritis/ Rheumatism	□ Cortisone Treatments	□ High Blood Pressure	□ Scarlet Fever
□ Artificial Heart Valve	□ Diabetes	□ HIV/ AIDS	□ Sickle Cell/ Trait
□ Artificial Joints (hip, knee, etc)	□ Emphysema	□ Jaundice	□ Sinus Problems
□ Asthma	□ Epilepsy/ Seizures	□ Kidney Trouble	□ Skin Rash
□ Autism	□ Excessive Bleeding	□ Liver Disease	□ Stomach Problems
□ Blood Transfusion	□ Fainting/ Dizzy Spell	□ Mental Disorders	□ Stroke
□ Bruise Easily	□ Glaucoma	□ Mitral Valve Prolapse	□ Swollen Ankles
□ Cancer	□ Head Injuries	□ Nervous/ Anxious	□ Tobacco Habit
□ Cerebral Palsy	□ Heart Attack	□ Neurological Disorder	□ Tonsillitis
□ Chemotherapy	□ Heart Disease	□ Pacemaker	□ Thyroid Problems
□ Chest Pain	□ Heart Murmur	□ Psychiatric/ Psych Care	□ Tuberculosis
□ Circulatory Problems	□ Heart Surgery	□ Radiation Treatment	□ Tumors
□ Cold Sores/ Fever Blisters	□ Hemophilia	□ Respiratory Problems	□ Ulcers
			□ Venereal Disease

MEDICATIONS
List Medications you are currently taking below:

_____
_____
_____
_____

ALLERGIES
List Allergies you have below:

_____
_____
_____
_____

MEDICAL HISTORY FORM AUTHORIZATION

Please provide your signature below to indicate you have completed this medical history form to the best of your knowledge and ability and have provided to Jonesville Family Dentistry accurate and through information regarding your medical history and contact information. We are required to ask you to update this form once every 12 months:

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Signature of Dentist Date