(Patient Medical History)

Date of Birth _____ SS# _____ Today's Date _____

Name _____
Last First Middle

Address _____ _____ _____ _____
City State Zip

Home Phone _____Cell Phone _____ Work Phone _____

Email Address _____
May we correspond via email or text? Yes No (please circle one)

Spouses Name and Phone # (parent if minor)_____ # _____

Name of your insurance company? _____

Is Insurance under Parent_____ Spouse_____Other_____

INSURANCE POLICY HOLDERS INFORMATION

Name _____

Social Security # or ID # _____ Date of Birth _____

Employers Name_____ Employers Phone _____

Employers Address_____

Insurance Authorization; I hereby authorize Paul W.Jakubowski, DDS to furnish copies of my records to my insurance company upon request. 1 hereby assign to Paul W.Jakubowski, DDS payments for dental services rendered to myself or my dependent. A copy of this signature is as valid as the original. I agree to be responsible for any co-pays, deductible anchor charges not covered by my insurance.

Signature _____ Please Print Name _____

Please Circle EACH Condition that Pertains to You, Previously or Currently
Your answers are for our records ONLY and will be considered Confidential.

AIDS/HIV	Epilepsy	Joint Replacement	Rheumatic Fever
Angina	Heart Attack	Kidney Disease	Sinus Problems
Arrhythmia	Herpes	Liver Disease	Stomach Problems
Asthma	Heart Murmur	Mitral Valve Prolapsed	Stroke
Cancer	Hepatitis	Other Heart Condition	Substance Abuse
Chest Surgery	High Blood Pressure	Pace Maker	Thyroid Disease
Diabetes	Depression	Pregnant/'Nursing	Tuberculosis

Other conditions not listed above? _____
Medications presently taking? _____
Allergic to ANY drugs? (Please list)_____
Do you require Pre-medication with antibiotics prior to dental treatment? _____
Any conditions relevant to your visit today?_____

Patient Signature (I certify the above medical information is correct) Date

Paul W. Jakubowski, D.D.S., P.A.
Phone (352) 243-2323 235 Hatteras Ave. Ste. 300, Clermont, FL. 34711 Fax (352) 243-2310

http://www.jakubowskicosmeticdentistry.com

OFFICE FINANCIAL AND INSURANCE POLICIES

Thank you for entrusting us with your dental care. We are making every effort to keep our cost down so that we can pass those savings on to you.

PLEASE READ AND SIGN

Full Payment is expected at the time services are rendered unless arrangements are made prior to your visit. We accept VISA, MASTER CARD, AMERICAN EXPRESS, DISCOVER and CARE CREDIT. There will be a $35.00 charge on all returned checks.

As a courtesy we will file your insurance. It is your responsibility to make sure that we receive prompt payment from them as you are ultimately responsible for the claim. Most insurance will not cover 100% of all dental expenses.

Please note that we are OUT OF NETWORK for all insurance companies, meaning we are a non-participating provider. Services will be paid at a "Usual and Customary Rate" by your insurance company and you are responsible for any remaining balance. Also, please understand that dental insurance is a contract between the patient and the insurance company and not a contract between the insurance company and the office. There are some insurance companies that will not assign benefits to us, meaning they will only send payment to the patient.

Any balance due on your account after 90 days will incur a 1.5% finance fee.

There will be a $35.00 charge for scheduled appointments canceled without 24 hour prior notice or failure to show up for a scheduled appointment.

For patients that would rather file their own insurance, the receipt you are given at the end of your visit contains all the information your insurance company needs to file your claim.

Again, thank you for choosing us. We will continue to strive to provide the best care possible in a professional, caring and courteous environment.

Your referral is the best compliment we could receive.

Date: ___/___ /_____ Signature:_____

(Patient/Parent or Responsible Party)

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information: DR. PAUL JAKUBOWSKI OR AUTHORIZED STAFF MEMBER: _____

B. Person(s) or Organization(s) authorized to receive the information: _____

C. Specific description of the information that may be used or disclosed (Including date(s)) _____

D. Specific description of how the Information will be used: _____

1) I understand that this authorization will expire on (insert date).
2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on the signed authorization) at any time by notifying *(Insert name practice)* In writing.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (If applicable).
4) I may inspect or copy any Information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date:

_____ _____
Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release (e.g. "results of a lab test performed on 1/4/03 or, if your entire medical record is included, all health information."}.
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).
You have the right to know who Is going to use It and what It is going to be used for. ***(e.g., John Smith, PhD / Research).***

HIPAA Authorization for Release of information
This form does not constitute legal advice and covers only federal, not state, laws.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

***Please** print your name here* _____ *Date* _____

Signature _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.
Due to an emergency situation it was not possible to obtain an acknowledgment.
We weren't able to communicate with the patient.
r info {Please provide specific details)

Employee Signature _____ ***Date*** _____