DANIEL PATRICK JONES, D.D.S., INC.
2 Scripps Drive, Suite 201
Sacramento, CA 95825

The major objective of this office is to provide you with the best quality dental care available anywhere. This service is based on a friendly, mutual but business-like understanding between doctor and patient. It is also felt that misunderstandings can be minimized if firm financial policies are agreed upon at the beginning of treatment. The following statements are made to acquaint you with our financial policy:

INSURANCE PATIENTS

1. We do require a form on the first visit. If you do not have a form on your initial visit, we ask that you please have your portion completed and signed by the second visit.

2. We will estimate the patients insurance coverage to the best of our ability.

3. Acceptance of insurance assignments by this office **does not absolve the patient of full responsibility** for payment of charges for professional services rendered. Payment of the patient's portion is due and payable at the time of the patient's visit to this office. The estimation of insurance coverage from our business department is to be considered a guideline until the final insurance payment is received and the patient's account has been reconciled.

CASH PATIENTS

1. Patients without insurance must make arrangements with the business manager. Cash, checks, and charge cards are accepted.

FINANCE CHARGES

1. All accounts must be reconciled within 60 days after treatment is complete. This includes insurance patients. A finance charge will be applied to each account after the 60 days. The patient is financially responsible for all charges whether or not paid by insurance companies. The patient further agrees that in the event of non payment to bear all costs of collection and reasonable attorney's fees. I authorize Daniel P. Jones, D.D.S., Inc. to release all information necessary to secure payment.

BROKEN APPOINTMENTS

1. Due to the fact we schedule the Doctor's time around our patients, we ask your consideration in calling if you are unable to make an appointment. In case of broken appointments with less than 24 hours notice, an additional fee may be charged.

RETURNED CHECKS

1. There will be a $30.00 handling fee for any returned checks.

DENTAL SERVICES

1. Services and fees will be discussed at any time either by phone or in person.

I CERTIFY that I have read and understood this Financial Policy.

Patient's Signature ______________________________ Date ______________
(Parents or Legal Guardian if patient is a minor)

Witness ______________________________ Date ______________
(Doctor's Representative)

Health History Form

ADA
American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle

Home Phone: Include area code ( )

Business/Cell Phone: Include area code ( )

Address: Mailing address

City: State: Zip:

Occupation:

Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) Include area codes

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

What is the reason for your dental visit today?

How do you feel about your smile?

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: Include area code ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

____

____

____

____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐

Date Treatment began: ______________

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐

If so, how interested are you in stopping?
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

	Yes	No	DK
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? ______________
If yes, how much do you typically drink in a week? ______________

WOMEN ONLY Are you:
Pregnant?
Number of weeks: ______________
Taking birth control pills or hormonal replacement?
Nursing?

	Yes	No	DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐

Date: ______________ If yes, have you had any complications?

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ______________	☐	☐	☐
Aspirin ______________	☐	☐	☐
Penicillin or other antibiotics ______________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ______________	☐	☐	☐
Sulfa drugs ______________	☐	☐	☐
Codeine or other narcotics ______________	☐	☐	☐
Metals ______________	☐	☐	☐
Latex (rubber) ______________	☐	☐	☐
Iodine ______________	☐	☐	☐
Hay fever/seasonal ______________	☐	☐	☐
Animals ______________	☐	☐	☐
Food ______________	☐	☐	☐
Other ______________	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ______________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, Specify: ______________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ______________			
Recurrent infections	☐	☐	☐
Type of infection: ______________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date

FOR COMPLETION BY DENTIST

Comments: ______________

PATIENT NAME: ______________________________

Last *First* *Initial*

I hereby authorize payment directly to Daniel P. Jones DDS., Inc.

(Dentist's Name)

of the dental benefits otherwise payable to me.

______________________________ ______________

SIGNATURE (Insured Person) **DATE**

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

Daniel P. Jones DDS., Inc.

(Attending Dentist's Name)

is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

______________________________ ______________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE **DATE**