Jay K. White, DDS, LTD.

Welcome

Date: ________________

Patient's Name: ______________________________**SSN:** __________________________ **Date of Birth:** _________________

Address: ____

City: _______________________________ **State:** ___________ **Zip:** _____________ **Sex: (Male)** _____ **(Female)** _____

Home Phone: ____________________________ **Work Phone:** _________________________ **Cell Phone:** ___________________

Status: Single ______ **Married** _____ **Divorced** _____ **Widow** _____ **Life Partner** _____ **Spouse Name:** __________________________

Employer: _________________________ **Occupation:** _________________________ **Email:** ______________________________

How did you hear about us? ____

In Case of an emergency, who should we notify? ____

Relationship: ____ **Phone#** ____

The purpose of your visit today? ____

Person(s) responsible for this account

Name: ____ **Relationship to patient:** _________________________________

Do you have Insurance? (Yes) ___ **(No)** ___ **if Yes, Name of insurance company:** ____

Policy Holders: If you have **Federal** Blue Cross/ Blue Shield, it is considered as your primary insurance.

Name of the Policy Holder: ____ **Date of Birth:** ___________________

SSN: ____ **Work Phone:** ____

Employer: ____ **Occupation:** ____

Do you have secondary insurance? **(Yes)** ___ **(No)** ___ **if Yes, Name of insurance company:** ______________________

Name of the Policy Holder: ____ **Date of Birth:** ___________________

SSN: ____ **Work Phone:** ____

Employer: ____ **Occupation:** ____

Terms and Conditions

Whether you have dental insurance or not, you have final responsibility for our treatment fees being paid.
We have extended financing plans available for qualified patients who need or want extensive treatment. In the event of a broken appointment with less than **24 hours notice,** a minimum fee of **$60.00** will be applied to your account. In the event that this account becomes past due, the doctors, their assigns, or lawful agents may consider the account in default and pursue collections procedures. If any account is past due, I agree to pay 1.5% interest per month (18% annum) on the unpaid balance from the due date, in addition to collection cost. Collection cost may include, but are not limited to, court filing fees, service or processing costs, and reasonable attorney fees of 30% of unpaid principal. Any returned check will be charged a fee of **$35.00.**

Signature of Patient, Parent, or Guardian: ____

Medical Information

Although dental personnel primarily treat the area of the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No ________________________________
Have you ever been hospitalized or had a major operation? Yes No ________________________________
Have you ever had a serious head or neck injury? Yes No ________________________________
Are you taking any medications, pills, or drugs? Yes No ________________________________
Do you use tobacco? Yes No
Do you use a controlled substance? Yes No

Females: Are you Pregnant/ trying to get pregnant? Yes No
Are you nursing? Yes No Taking Oral Contraceptives? Yes No

Are you Allergic to any of the following? **(Please circle)**
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other ____________________

Health Information

***PLEASE CHECK THOSE THAT APPLY**

□AIDS/HIV +
□Alzheimer's Disease
□Anaphylaxis
□Anemia
□Angina
□Arthritis/ Gout
□Artificial Heart Valve
□Artificial Joint
□Asthma
□Blood Disease
□Blood Transfusion
□Breathing Problems
□Bruise easily
□Cancer
□Chemotherapy
□Chest Pains
□Cold Sores/ Fever Blisters
□Congenital Heart Disorder
□Convulsions
□Cortisone Medicine
□Diabetes
□Drug Addiction
□Easily Winded
□Emphysema
□Epilepsy or Seizures
□Excessive Thirst
□Fainting Spells/ Dizziness
□Frequent Cough
□Frequent Diarrhea
□Frequent Headaches
□Genital Herpes
□Glaucoma
□Hay fever
□Heart Attack/ Failure
□Heart Murmur
□Heart Pace Maker
□Heart Trouble/ Disease
□Hemophilia
□Hepatitis A
□Hepatitis B or C
□Herpes
□High Blood Pressure
□Hives or Rash
□Hypoglycemia
□Irregular Heartbeat
□Kidney Problems
□Leukemia
□Liver Disease
□Low Blood Pressure
□Lung Disease
□Mitral Valve Prolapse
□Pain in Jaw Joints
□Parathyroid Disease
□Psychiatric Care
□Radiation Treatments
□Recent Weight Loss
□Renal/ Kidney Disease
□Rheumatic Fever
□Rheumatism
□Scarlet Fever
□Shingles
□Sickle Cell
□Sinus Trouble
□Spine Bifida
□Stomach/ Intestinal Disease
□Stroke
□Swelling of Limbs
□Thyroid Disease
□Tonsillitis
□Tuberculosis
□Tumors or Growths
□Ulcers
□Venereal Disease
□Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No

Name and phone number and/or address of Primary Physician? : ________________________________

List of Medications: ________________________________

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Date and reason for last dental visit:

Date of last x-rays:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be detrimental to my (or Patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: ________________________________ Reviewed by: __________

Office Policies

Our professional treatment is rendered to you, not the insurance company. You are responsible for payment of all treatment. As a courtesy to you we will file your insurance claims for you as long as you can go to the **Dentist of your choice**.

Please understand that your insurance policy is a contract between you and your insurance company. Any problems with a non-payment, is your responsibility. Remember that dental benefits were never intended to dictate your dental care; they are to assist in payment of dental care.

Any insurance balance over 60 days old is considered delinquent and is your responsibility to pay.

Your dental benefits were determined by your employer and insurance company and not by this office. Most policies cover a percentage of what they call "Usual and Customary Fee". However the insurance companies establish these fees based on their needs and not yours. These fees are not always the same as the fees charged in this office.

We will do our best to see that you receive your full benefits. However, ultimate responsibility for payment is yours. Financial arrangements must be made before dental treatment begins.

Authorization and Release

I have read the above office policy, terms and conditions of treatment and payment and agree to their content.
I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the release of information necessary to process all dental claims and authorize payment to Jay K. White, DDS, LTD. for professional services rendered.

Signature: ____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices from the office of Jay K. White, DDS, LTD. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Jay K. White, DDS, LTD reserves the right to change the privacy practices that are describes in the statement of privacy practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family	□Yes	□No
Spouse only	□Yes	□No
Other (please specify) ______________________	□Yes	□No

Print Patient's Name: ____

Signature of Patient Parent, or Guardian: ____ Date: ____________________

OFFICE USE ONLY

Record of Acknowledgement given before treatment? Yes No

Reason for Denial: ____

Reviewed by: ________________________________ **Date Provided:** _______________