JONES
DENTAL CARE

ADULT FORM

WELCOME! WE WANT YOU TO KNOW THAT WE WILL DO OUR VERY BEST TO PROVIDE YOU WITH THE MOST PLEASANT DENTAL EXPERIENCE POSSIBLE. TO HELP US IN THIS WE NEED TO HAVE BOTH THE FRONT AND BACK SIDES OF THIS FORM FILLED OUT WITH AS MUCH DETAIL AS POSSIBLE. WE PRIDE OURSELVES IN OUR ACCURACY AND OUR ATTENTION TO DETAIL. IT MAKES OUR JOB EASIER IF WE CAN GET ALL OF YOUR CHILD'S INFORMATION CHARTED PROPERLY. THANK YOU FOR YOUR PATIENCE. SINCERELY, DR. AMMON JONES & DR. AARON JONES

PATIENT INFO:

_____ _____
NAME (FIRST, MI, LAST) PREFERRED NAME

MUST GIVE THE SAME NAME GIVEN TO YOUR INSURANCE

[ ] MALE [ ] FEMALE [ ] MARRIED [ ] SINGLE [ ] WIDOWED [ ] FULL-TIME STUDENT @_____

PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS (PLEASE CHECK ONE):

[ ] TEXT [ ] CELL PHONE [ ] HOME PHONE [ ] WORK [ ] EMAIL_____

_____
ADDRESS (STREET/APT) **CITY** **STATE** **ZIP CODE**

_____ _____ (_____)_____ (_____)_____ (_____)_____
BIRTH DATE (M/D/Y) SOCIAL SECURITY NUMBER CELL PHONE WORK PHONE HOME (LAND LINE) PHONE

SPOUSE INFO:

_____ _____ [ ]M [ ]F
NAME (FIRST, MI, LAST) PREFERRED NAME

_____
ADDRESS (IF DIFFERENT) **CITY** **STATE** **ZIP CODE**

_____ _____ (_____)_____ (_____)_____ (_____)_____
BIRTH DATE (M/D/Y) SOCIAL SECURITY NUMBER CELL PHONE WORK PHONE HOME (LAND LINE) PHONE

PATIENT'S HEALTH INFO:

[ ] AIDS/HIV +	[ ] DIABETES	[ ] HEPATITIS	[ ] BLEEDING DISORDER
[ ] MENTAL DISORDER	[ ] PREGNANT NOW	[ ] HEAD/JAW INJURY	[ ] PENICILLIN ALLERGY
[ ] PACEMAKER	DUE DATE:_____	[ ] CODEINE ALLERGY	[ ] HEART DISEASE
[ ] RHEUMATIC FEVER	[ ] FAINTING/DIZZINESS	[ ] ARTIFICIAL JOINTS	[ ] HIGH BLOOD PRESSURE
[ ] ASTHMA	[ ] EPILEPSY	[ ] HEART MURMUR	[ ] SINUS PROBLEM

[ ] ALLERGIES: (PLEASE LIST)_____

ARE YOU CURRENTLY TAKING ANY MEDICATION(S)? IF YES, PLEASE LIST:

_____

_____

IF YOU'RE BEING TREATED BY A PHYSICIAN WHOM WE MAY NEED TO CONSULT, PLEASE EXPLAIN & GIVE HIS/HER NAME & NUMBER:

_____

PLEASE DETAIL ANY UNUSUAL COMPLICATION OR REACTION YOU MAY HAVE HAD TO PREVIOUS DENTAL TREATMENT:

_____

_____

ARE YOU PARTICULARLY ANXIOUS ABOUT WORK? IF SO, DO YOU PREFER THAT WE OFFER YOU NITROUS OXIDE (LAUGHING GAS) OR OTHER SEDATION?

_____

ANY PRECEDING INFORMATION THAT APPLIES TO ME HAS BEEN FILLED IN CORRECTLY. IF I HAVE ANY PERTINENT CHANGES IN MY HEALTH HISTORY PRIOR TO FUTURE DENTAL VISITS I WILL INFORM YOU.

X_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE RELATIONSHIP TO PATIENT

CONTINUED

ADULT FORM

EMPLOYMENT INFO

FOR PATIENT _____ _____

EMPLOYER NAME — WORK PHONE

_____ _____

ADDRESS (STREET/APT) — CITY — STATE — ZIP

FOR SPOUSE _____ _____

EMPLOYER NAME — WORK PHONE

_____ _____

ADDRESS (STREET/APT) — CITY — STATE — ZIP

DENTAL INSURANCE INFO:

PRIMARY INSURANCE:

PATIENT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER

_____ _____

NAME OF INSURED — INSURED'S BIRTH DATE (M/D/Y)

_____ _____

SSN OR SUBSCRIBER ID — GROUP NUMBER

_____ _____

INSURED'S EMPLOYER NAME — INSURANCE PHONE NUMBER

_____

INSURANCE CO. NAME AND ADDRESS — CITY — STATE — ZIP CODE

_____

INSURED'S ADDRESS (IF DIFFERENT THAN PATIENT'S) — CITY — STATE — ZIP CODE

SECONDARY INSURANCE:

PATIENT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER

_____ _____

NAME OF INSURED — INSURED'S BIRTH DATE (M/D/Y)

_____ _____

SSN OR SUBSCRIBER ID — GROUP NUMBER

_____ _____

INSURED'S EMPLOYER NAME — INSURANCE PHONE NUMBER

_____

INSURANCE CO. NAME AND ADDRESS — CITY — STATE — ZIP CODE

_____

INSURED'S ADDRESS (IF DIFFERENT THAN PATIENT'S) — CITY — STATE — ZIP CODE

REFERRAL INFO:

WE LOVE TO REWARD THOSE WHO REFER OTHERS TO OUR PRACTICE. SEND IN A FRIEND AND WE'LL SEND YOU A GIFT!
WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

_____

CONSENT TO EXAMINE & PROVIDE TREATMENT

AS A CONDITION OF TREATMENT BY THIS OFFICE I GIVE CONSENT TO THE DOCTORS AND STAFF OF JONES DENTAL CARE TO EXAMINE AND DIAGNOSE MY DENTAL & OROFACIAL STRUCTURES & TO PROVIDE TREATMENT WITH MY VERBAL APPROVAL.

X _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN — DATE — RELATIONSHIP TO PATIENT

JONES
DENTAL CARE

FINANCIAL POLICIES

We are dedicated to providing you with the best possible dental care. To give our patients this level of customer service will require that we have some financial and insurance policies. It is important that you read carefully and understand each of the following statements.

INSURANCE

We help file your insurance claims as a courtesy and a convenience to you. **Your insurance coverage is a contract between you, your employer and the insurance company.** We are not a party to this contract. **Our relationship is with you and not with your insurance company. All charges are your responsibility.** Our office will submit your dental claims to your first and if applicable your secondary insurances as a courtesy. It is your responsibility to provide us with the correct current insurance information and to understand your benefits and monitor what has been paid to our office should you be close to using up your benefits. It is also your responsibility to confirm that the doctor you are seeing is on your insurance provider list and to obtain referrals if necessary.

CHARGES

We require all deductibles and co-payments to be made at the time of service. If payment is not made at the time of service, there will be a **delayed payment fee of $25.00. Your appointment may also be rescheduled and there could possibly be a fee for the loss of doctor or hygiene time.** We have no control over what your insurance company will or will not choose to pay. We will estimate your dental treatment to the best of our ability. However, all charges for treatment are ultimately the patient's responsibility. There is an interest rate of 24% APR (2% added to balance monthly) on **ANY** unpaid balances, including delayed insurance claims. If your account becomes 90-day delinquent, the account will automatically be sent to a collections agency. A 50% service fee will be assessed.

APPOINTMENTS

We require that all patients confirm any appointments they have made with the office. If appointments are not confirmed, the office may cancel those appointments. There may be a charge of $60 per hour of the doctor or hygiene time if you are not able to give the office a 2-business day notice of cancellation.

I grant permission to the staff to telepone me at home, work or on my cell to discuss matters related to this form. I have read, understand and agree to the policies listed above.
(minors must have signature of parent or guardian before being seen)

SIGNATURE _____ DATE _____