JONES DENTAL CARE

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, and it makes our jobs easier if we can get all of your information charted properly. Thank you for your patience.

Sincerely, Dr. Ammon Jones and Dr. Aaron Jones

Patient Information

Name: _____ You go by: _____
First MI Last Preferred Name

☐ Male ☐ Female ☐ Married ☐ Single ☐ Widowed ☐ Full time student @ _____

Birth Date:_____ Social Security #: _____

Phone #'s Home: _____ Work: _____ Mobile: _____

Address: _____
Street Apartment #

_____
City State Zip

Email address: _____

Optional Alternate Contact: _____ Phone Number: _____

Spouse Information

Name:_____Preferred Name:_____

Birth Date:_____ Social Security #: _____

Phone #'s Home: _____ Work: _____ Mobile:_____

Address (if different): _____
Street Apartment #

_____
City State Zip

Health Information

Please check any of the following that apply concerning your current health status:

- ❑ AIDS / HIV+
- ❑ Allergies: (list) _____ _____
- ❑ Artificial joints
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Codeine Allergy
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting/Dizziness
- ❑ Head/Jaw injury
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Press.
- ❑ Mental Disorders
- ❑ Pacemaker
- ❑ Penicillin Allergy
- ❑ Pregnant now? Due date_____
- ❑ Rheumatic fever
- ❑ Sinus problems

Please list all medications that you are currently taking (or attach a copy)_____
_____

If you are being treated by a physician who we may need to consult please explain and give his/her name and office number:_____

Please detail any unusual complication or reaction you may have had to previous dental treatment:_____
_____

Are you particularly anxious about dental 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._____
signature date

Referral Information

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?_____

Employment Information

The following is for the patient:

Employer Name: _____ Work Phone:_____

Address: _____
Street City State Zip Code

The following is for the spouse of the patient:

Employer Name: _____ Work Phone:_____

Address: _____
Street City State Zip Code

Insurance Information

Primary Insurance

Name of Insured: _____ Insured's Birth Date: _____

Social Security Number or Subscriber I.D. _____ Group # _____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Name, Address: _____

_____

Insurance Company Phone Number: _____

Secondary Insurance

Name of Insured: _____ Insured's Birth Date: _____

Social Social Number or Subscriber I.D. _____ Group # _____

Insured's Address:

_____
Street City State Zip Code

Insured's Employer Name:_____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Co. Name, Address: _____

_____ Phone Number: _____

Office Financial Policies and Consent to Examine and Provide Treatment

As a condition of treatment by this office I give consent to Jones Dental Care to examine and diagnose my dental and orofacial structures and to provide treatment with my verbal approval. An estimate will be given to me of my expenses, but I agree to be responsible for the payment of all costs of dental work provided for me regardless of any third party reimbursement. I understand that the doctors and staff will provide only treatment which is intended to be for my benefit, and any unforeseen situation which may lead to unintended discomfort, inconvenience, loss of tooth structure, or unfortunate circumstance is related only to the situation presented to Dr. Ammon Jones, Dr. Aaron Jones, and Associates and their staff by my mouth. I will not consider Dr. Ammon Jones, Dr. Aaron Jones, or Associates, nor their staff to be responsible for any circumstances that originate with my oral condition.

Regarding my dental insurance, I understand that some dental services may be billed to the insurance company as a courtesy of this office. I agree to pay any deductibles and/or co-payments as estimated by the office at the time of service. I further understand that if my insurance company refuses payment to the doctor for any reason, I am responsible for the payment of the balance. I understand that all estimates are an approximation of expenses and are not guaranteed.

I agree to pay all costs and reasonable attorney fees if suit were instituted hereunder to collect monies owed by me, including charges of up to 50% that may be assessed to us by any collection agency retained to pursue collections.

I grant my permission to you or your assignee, to telephone me at home or at my work and/or to leave messages for me to discuss matters related to my dental treatment, payment arrangements, insurance, and/or appointments.

I certify that I have read, understood, and answered all questions accurately, and I agree to abide by the conditions in this section.

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian