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 side 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 child's information charted properly. Thank you.

Sincerely, Ammon & Aaron Jones

Patient Information

Name: _____ _____
First MI Last Preferred Name

☐ Male ☐ Female Birth Date:_____ Home Phone: _____

Address: _____
Street Apartment #

_____
City State Zip

Parental Information

Father: _____ Birth Date: _____

Social Security #: _____ Work Phone: _____ Cell Phone: _____

Address: _____
Street Apartment #

_____
City State Zip

Mother: _____ Birth Date: _____

Social Security #: _____ Work Phone: _____ Cell Phone: _____

Address: _____
Street Apartment #

_____
City State Zip

Health Information

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

- ❑ Allergies: (list) _____
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Codeine Allergy
- ❑ Epilepsy
- ❑ Head/Jaw injury
- ❑ Heart Murmur
- ❑ Penicillin Allergy
- ❑ Rheumatic fever
- ❑ Sinus problems

Please list any other health issue that could affect your child's dental treatment: _____

_____

If your child is currently 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 your child may have had to previous dental treatment:

_____

_____

Is your child particularly anxious about dental appointments or dental work? _____

Are you comfortable if at future appointments we use Nitrous Oxide (laughing gas) for a minimal charge to make the dental experience more pleasant for him or her?_____

By signing below I certify that all of the above information is accurate and correct. If any of the above information including the health history changes in the future I will inform the staff of this office.

_____ _____
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 card!

Who may we reward for referring you to our practice?_____

Employment Information

The following is for the **father** of the patient:

Employer Name: _____ Work Phone:_____

Address: _____
Street City State Zip Code

The following is for the **mother** 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: ☐ Child ☐ Other_____

Insurance Co. Name, Address: _____

_____

Insurance Company Phone Number: _____

Secondary 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: ☐ 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 the doctors and staff of Jones Dental Care to examine and diagnose my child's teeth and mouth, and to provide treatment with my verbal approval. An estimate will be given to me of my expenses, and I agree to be responsible for the payment of these expenses regardless of any third party reimbursement. I understand that Jones Dental Care 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 by the condition of my mouth. I will not consider the doctors or staff of Jones Dental Care 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 Jones Dental Care. 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 this office 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 be 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 the staff to telephone me at home or at my work to discuss matters related to this form.

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