1141 S. Eustis St.
Eustis, FL 32726

office: 352.589.2099
fax: 352.589.6046

web: jacksondentistry.com

WELCOME TO JACKSON DENTISTRY — TELL US ABOUT YOURSELF

First Name: ______________ Last Name: ______________ MI: ____ Title: ______________

Preferred Name: ______________________________ Male: ◯ Female: ◯

Address: ______________________ City: ______________ State: ____ Zip: ______

SSN: ______________________ DOB: ______________________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Email Address: ______________________

Employer: ______________________ Occupation: ______________________

Marital Status:

How did you hear about our office?

OTHER: ____

PRIMARY INSURANCE INFORMATION

Subscriber Name: ______________________ Relationship to Patient: ________ Subscriber DOB: ________

Subscriber SSN/ID: ______________________ Subscriber Employer: ______________________

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: ______________________ Group Number: ______________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Jackson Dentistry all insurance benefits, if any, otherwise payable, to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ______________________ Relationship: ______________ Date: ________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient / Guardian Signature: ____

MEDICAL HISTORY

Do you have a personal physician? Yes: ◯ No: ◯

Physician's Name: ______

Physician's Phone: ______

Date Of Last Visit: ______

Your current physical health? Good: ◯ Fair: ◯ Poor: ◯

Currently under the care of a physician? Yes: ◯ No: ◯

Please Explain: ______

Do you use tobacco in any form? Yes: ◯ No: ◯

Any metal rods, pins or implants placed? Yes: ◯ No: ◯

Are you taking any medications? Yes: ◯ No: ◯

Please list each one: ______

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

Yes:	No:	CONDITIONS
◯	◯	Abnormal bleeding
◯	◯	Alcohol abuse
◯	◯	Allergies
◯	◯	Anemia
◯	◯	Angina pectoris
◯	◯	Arthritis
◯	◯	Artificial heart valve
◯	◯	Asthma
◯	◯	Blood transfusion
◯	◯	Cancer
◯	◯	Chemotherapy
◯	◯	Colitis
◯	◯	Congenital heart disease
◯	◯	Diabetes
◯	◯	Difficulty breathing
◯	◯	Drug abuse
◯	◯	Emphysema
◯	◯	Epilepsy
◯	◯	Facial surgery
◯	◯	Fainting spells
◯	◯	Fever blisters
◯	◯	Frequent headaches

Yes:	No:	CONDITIONS
◯	◯	Glaucoma
◯	◯	HIV + AIDS
◯	◯	Heart attack
◯	◯	Heart murmur
◯	◯	Heart surgery
◯	◯	Hemophilia
◯	◯	Hepatitis A
◯	◯	Hepatitis B
◯	◯	Hepatitis C
◯	◯	High blood pressure
◯	◯	Joint replacement
◯	◯	Kidney problems
◯	◯	Liver disease
◯	◯	Low blood pressure
◯	◯	Mitral valve prolapse
◯	◯	Pace maker
◯	◯	Psychiatric problems
◯	◯	Radiation therapy
◯	◯	Rheumatic fever
◯	◯	Seizures
◯	◯	Sexual transmitted disease
◯	◯	Shingles

Yes:	No:	CONDITIONS
◯	◯	Sickle cell disease
◯	◯	Sinus problems
◯	◯	Stroke
◯	◯	Thyroid problems
◯	◯	Tuberculosis
◯	◯	Ulcers

Yes:	No:	ALLERGIES
◯	◯	Aspirin
◯	◯	Codeine
◯	◯	Dental anesthetics
◯	◯	Erythromycin
◯	◯	Jewelry / Metals
◯	◯	Latex
◯	◯	Penicillin
◯	◯	Tetracycline
◯	◯	Other

Yes:	No:	IF FEMALE, PLEASE ANSWER
◯	◯	Taking birth control pills?
◯	◯	Are you pregnant?
		If so, how many weeks? ______
◯	◯	Are You Nursing?

Person to contact in case of emergency: ______

Relationship: ______

Address: ______

Phone Number: ______

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: ______

Date: ______

DENTAL HISTORY

How may we help you today? ______________________________

____

____

Your current physical health? Good: ◯ Fair: ◯ Poor: ◯

Require antibiotics before dental treatment? Yes: ◯ No: ◯

Are you currently in pain? Yes: ◯ No: ◯

Have you ever had gum treatment? Yes: ◯ No: ◯

Do you now, or have you had, any pain or discomfort in your jaw joint? (TMJ) Yes: ◯ No: ◯

Are you under any stress? (new job, moving, relationships, etc.) Yes: ◯ No: ◯

Do you like your smile? Yes: ◯ No: ◯

Is there anything you would like to change about your smile? Yes: ◯ No: ◯

Are you happy with the color of your teeth? Yes: ◯ No: ◯

Do your gums bleed? Yes: ◯ No: ◯

How many times do you: Floss per week? ______________ Brush per day? ______________

Are your teeth sensitive to heat, cold, or anything else? Yes: ◯ No: ◯

Have you lost any teeth? Yes: ◯ No: ◯

Have you ever had a serious / difficult problem with any previous dental work? Yes: ◯ No: ◯

Have you ever had any unfavorable dental experiences? Yes: ◯ No: ◯

When was your last dental cleaning? ______________

When was your last dental visit? ______________

When did you leave your previous dentist? ______________

How can we accommodate you better during your dental visit? ______________________________

____

Here at Jackson Dentistry we offer a wide variety of services to enhance and keep your smile beautiful.
Please circle any services below you would like our friendly staff to discuss with your during your visit.

TEETH WHITENING	VENEERS / LUMINEERS	DENTAL IMPLANTS
SMILE MAKEOVER	BONDING	SEALANTS
CROWN AND BRIDGE	IMPLANT CROWNS	PARTIALS / DENTURES
NIGHT / SPORT GUARDS	ORTHODONTICS (BRACES/SIX MONTH SMILES)	

1141 S. Eustis St.
Eustis, FL 32726

office: 352.589.2099
fax: 352.589.6046

web: jacksondentistry.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 9, 2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

USES AND DISCLOSURES OF HEALTH INFORMATION

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before June 9, 2010. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Tanya Merritt
Telephone: (352) 589.2099
Fax: (352) 589.6046
Email: tanya@jacksondentistry.com
Address: 1141 S. Eustis St.
Eustis, FL 32726

1141 S. Eustis St.
Eustis, FL 32726

office: 352.589.2099
fax: 352.589.6046

web: jacksondentistry.com

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our Website. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

This HIPAA Consent was signed by: ______________________________ **Date:** ____________________

1141 S. Eustis St.
Eustis, FL 32726

office: 352.589.2099
fax: 352.589.6046

web: jacksondentistry.com

FINANCIAL POLICY

Your treatment plan will include a detail of all fees. We will inform you of all foreseeable costs before treatment. Fees are payable at the time of service or by a prearranged payment plan.

We offer multiple financing options. We will make special arrangements as needed. You will be able to talk with our financial coordinator when you choose and approve your treatment.

We will submit most benefit plan claims for you. We will work with you to obtain your full plan benefits. However, you (or a guardian) are personally responsible for your account balance.

INSURANCE / BENEFIT PLANS

Our office is committed to maximizing insurance benefits that you may have. Because plan policies vary, we estimate your coverage in good faith but cannot guarantee that coverage due to the complexities of plan contracts.

We ask that your estimated patient portion be paid at the time of service. If you have any questions, our courteous staff is always available to address them. In this age of diminishing dental benefits, we pledge to work with you to obtain the dentistry that you desire as if you have no insurance benefit.

Indeed many of our patients do not have a dental plan. If you do, be careful not to let the "plan" choose your treatment path.

Patient Signature: ______________________________ **Date:** ________________

1141 S. Eustis St.
Eustis, FL 32726

office: 352.589.2099
fax: 352.589.6046

web: jacksondentistry.com

CANCELLATION AND NO-SHOW POLICY

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone.

Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will be understanding of the situation. At some point, they may need the same courtesy too!

Like many offices, this office does call to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of $25 per 30 minutes of scheduled time for a broken appointment or cancellation with less than 24 hours' notice for your appointment.

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

Patient Signature: ______________________________ Date: ______________