Welcome! We are glad you are here!

Patient Full Name: ..... (Male/Female)

I prefer to be called: ..... Date Today: .....

Address: ..... City, Zip: .....

Date of Birth: ..... Social Security # .....

Your Phone: ..... Email: .....

Emergency Contact: ..... Emergency Phone: .....

Insurance:

Employer: ..... Group # (Plan or Policy #): .....

Dental Insurance Company: ..... (provide card for copy)

Person responsible for the account if other than patient: .....

Billing Address (if different): .....

Insured's Name (if other than patient): .....

Insured's Social Security # ..... Insured's Date of Birth: .....

Dental & Medical History:

Are you allergic to any medications? Which ones: .....

Are you being treated for any medical condition? If yes, please explain: .....

.....

List any medications you are currently taking: .....

.....

WOMEN: Are you pregnant or nursing? YES NO

Do you clench or grind your teeth at night or during the day?	Y	N
Have you experienced any growth or sore spots in your mouth?	Y	N
Do your gums bleed?	Y	N
Do you frequently get blisters on your lips or in your mouth?	Y	N
Do you have any trouble keeping your mouth open?	Y	N
Are your teeth sensitive to hot or cold?	Y	N

Have you had any of the following:

Heart attack or bypass	YES	NO
Heart valve disease	Y	N
Mitral Valve Prolapse	Y	N
Rheumatic fever	Y	N
High or low blood pressure	Y	N
Blood Disease	Y	N
Bleeding Problems (Hemophilia)	Y	N
Diabetes	Y	N
Respiratory (Asthma, Emphysema, TB)	Y	N
Hepatitis	Y	N
Kidney Disease	Y	N
Stomach or intestinal problems (ulcers)	Y	N
Epilepsy	Y	N
Hip or joint replacement	Y	N
Exposure to AIDS virus	Y	N
Substance abuse	Y	N
Venereal Disease	Y	N
Cancer or cancer treatment	Y	N

Financial Agreement and Treatment Consent:

- I understand that I am responsible for the balance on my account regardless of my insurance status, and that payment is due at the time of service.
- I authorize release of any information necessary to effectively process my claim with my insurance carrier.
- I authorize payment directly to my attending dentist of the group insurance benefits otherwise payable to me.
- I affirm that the information I have provided is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
- I consent to the use of photographs of my teeth/mouth for educational or marketing purposes.
- I authorize the dental staff to perform the necessary dental services I may need.

Signature ..... **Date:** .....

If you are filling this form for someone other than yourself, please indicate your relationship to the patient: .....

Notice of Privacy and Consent

Jaquery Dental Inc.

56 Penny Lane Suite C, Watsonville CA 95076

Definitions

- The **Health Insurance Portability and Accountability Act** (HIPAA) is designed to protect the privacy of patients.
- A HIPAA Consent is a document that a patient signs to confirm receipt or acknowledgement of a Notice of Privacy Practices statement from the health practitioner's office as required by law.
- The full statement is available at Jaquery Dental Inc. It is also on the Jaquery Dental Inc. website, www.FreshSmileWatsonville.com.

Notice of Consent

- I understand that I have rights to privacy regarding my health information, according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this Consent I authorize Jaquery Dental Inc. to use and disclose my protected health information to:

  Provide dental treatment (including direct or indirect providers affiliated with Jaquery Dental Inc.)

  Obtain payment from third party payers (e.g. insurance companies)

  Conduct day to day healthcare operations at Jaquery Dental Inc.
- I have been informed of, and given the right to review and secure a copy of a Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice and that I may contact you at any time to attain the most current version.
- I understand that I have the right to request restrictions on how my protected health information is used and disclosed to receive treatment, authorize payments, and enable healthcare operations, but that you are not required to agree to any restrictions I may request. However, if you do agree, you are bound to comply with my requested restrictions.
- I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Consent for Release of Confidential Information

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the delivery of proper dental care.
- I authorize release of any information concerning my (or my child's) healthcare, for advice, evaluation and treatment, and to manage claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment by another dentist or another healthcare professional and their staff.

Financial Responsibility

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that while my dentist and staff will *estimate* insurance benefits, I am responsible for payment of the account, and for providing correct insurance information.

I understand that if insurance is not applicable when dental services are rendered, full payment is due at the time of service.

Do We Have Permission for the Following?

- Leave a reminder of your appointment on your voicemail, or by text message?
- Speak to other members of your household regarding your appointment?
- Discuss your dental appointment with any member of your household?
- Leave a message at your place of employment?
- If YES to any of the above, whom? .....

Patient's Name: .....

Signature: .....

Date: .....