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: .....

How did you hear about us? .....

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 pregnant or nursing? YES NO

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

.....

Medications you are currently taking: .....

.....

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.
- *Installments will accrue an APR (annual percentage rate) of 10%.*
- 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: .....

Financial Agreement – Jaquery Dental Inc

Thank you for choosing us for your dental care. We're committed to providing excellent service and transparent communication. Please review the following terms and let us know if you have any questions—we're happy to help!

💳 Payment Terms

- Payment is due at the time of service unless prior arrangements have been made.
- We accept cash, credit/debit cards, and third-party financing options such as WithCherry.com, and CareCredit.com.
- **A $125 late fee may apply to overdue balances after 90 days.**

🏥 Insurance & Benefits

- As a courtesy, we will bill your dental insurance. Any estimate we provide is based on available information, and **not a guarantee of payment**.
- **You are responsible for any balance not covered by insurance.**

⏰ Missed Appointment Policy

- Kindly provide at least 24 hours' notice to cancel or reschedule.
- **A fee of $75** may be charged for **missed appointments or cancellations within 24 hours of your appointment**.

🔒 Credit Card Authorization

- With your permission, we may securely store your credit card on file for processing account balances related to care.
- You may revoke this authorization in writing at any time.

📄 Credit Reporting Statement (Required by Law)

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

⚖️ Additional Terms

- Delinquent accounts may be referred to collections if not resolved within **90 days**.
- Any legal disputes will be governed under the laws of the State of California, County of Santa Cruz.

By signing below, you acknowledge and agree to the terms outlined above.

Patient/Guardian Signature: _____ Date Today: _____

Jaquery Dental Inc – HIPAA Consent

Patient Consent for Use and Disclosure of Protected Health Information

As part of your dental care, we may need to use or disclose your health information for treatment, payment, and healthcare operations. This form outlines your rights and our responsibilities under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

📋 Your Rights

- You have the right to review our **Notice of Privacy Practices** before signing this consent.
- You may request restrictions on how your information is used or disclosed.
- You may revoke this consent in writing at any time (except where we've already acted on it).

🛡️ Our Responsibilities

- We will use your information only as permitted by law and this consent.
- We may contact you by phone, email, or mail to confirm appointments or provide information related to your care.
- We may share your information with other healthcare providers, insurance companies, or labs as needed for your treatment.

📞 Communication Preferences

- May we call, text, or email you to confirm appointments? ☐ Yes ☐ No
- May we leave a voicemail or message on your phone? ☐ Yes ☐ No
- May we discuss your dental care with a family member? ☐ Yes ☐ No
  If yes, please list their name(s): _____

By signing below, you acknowledge that you have read and understood this consent and agree to the use and disclosure of your health information as described.

Patient Name (Print): _____

Signature: _____

Date: _____

Witness: _____

Date: _____