**Written Financial Policy**

Thank you for choosing Jackson Family Dental! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and affordable for our patients as possible by offering these payment options:
-Cash, Visa, Mastercard, Discover and American Express
-CareCredit: We offer financing through a third-party lending company specializing in dental care. CareCredit offers interest free plans for up to 12 mos. Applications are processed online at our office or on your own personal computer in the privacy of your home.

**Dental Insurance**

We are a Delta Premier and Cigna Radius provider. As a service to you, we will file claims with all carriers and do our best to obtain maximum benefits for our patients. Any remaining balance unpaid by the insurance company within 60 days is the responsibility of the patient. Balances over 90 days will be forwarded to a collection agency.

**Payment Policy**

You agree, in order for us to service our account or to collect any amounts you owe, our organizations representatives, or debt collections agency, may contact you by telephone, including wireless telephone numbers associated with your account, emails or text messages. I/We have read this disclosure and agree that the Lender/Creditor, and its ancillary providers, HIPPA business associates, vendors and its debt collection agents may contact me/us as described above.
-We require 24 hour notice if you need to cancel or reschedule your appointment. A $45 fee will be charged if this consideration is not given.
-Checks returned for insufficient funds will result in an additional $25 charge.

***All treatment plans provided are estimates only. Benefits paid are dependent on your insurance company. There will be an out of pocket portion required at the time of service with the exception of most dental cleaning appointments.***

_____ _____

Patient Name (please print) Patient, Parent or Guardian Signature

Date: _____

JACKSON FAMILY DENTAL

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

## SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jesse L Jackson, DDS

Telephone: 816-429-5799 Fax: 816-245-7867

E-mail: jacksonfamilydentalonline@gmail.com

Address: 26 S Village Drive Liberty, MO 64068

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**

# PATIENT INFORMATION

Date: _____

First Name:_____ MI:____ Last:_____ Preferred:_____

Birth Date:_____ Age:_____ SS#:_____ Sex: M F

Cell Phone:_____ Work Phone:_____EXT_____ Home Phone:_____

Which is the best Number/Time to reach you? _____ Text/Email reminders?_____

Address:_____City:_____ State:_____ Zip:_____

Email:_____ □ Married/Partnered □ Widowed □ Single □ Minor

Emergency Contact:_____ Relationship:_____Phone:_____

Who may we thank for referring you?_____

# DENTAL INSURANCE INFORMATION

## PRIMARY

Insurance Company_____

Customer Service Phone Number_____

Employer_____

Group Name_____Group Number_____

Subscriber_____ DOB_____

Subscriber/Member ID/SSN_____

Relationship to Patient _____

## SECONDARY

Insurance Company_____

Customer Service Phone Number_____

Employer_____

Group Name_____Group Number_____

Subscriber_____ DOB_____

Subscriber/Member ID/SSN_____

Relationship to Patient _____

# DENTAL HISTORY

Date of last dental visit: _____

Name of your previous dentist: _____

Reason for your visit today: _____

Have you ever had an oral cancer screening? Y N

How often do you brush? _____

How often do you floss? _____

Have you/family member ever been treated for periodontal disease? Y N

Have you ever had complications from an extraction? Y N

Have you ever had popping/clicking near your ear when you chew? Y N

Are you prone to frequent headaches? Y N

Do you grind/clench your teeth? Y N

Do you have □ Sores □ Blisters □ Loose/Broken fillings

□ Dry Mouth □ Food Collection □ Bleeding Gums

□ Mouth Breathing □ Nail Biting □ Chew on one side

Swollen/Tender □ Gums □ Lips □ Cheeks

Have you ever had Orthodontic treatment? Y N

Do you snore? Y N

Do you have problems with bad breath? Y N

Have you ever had an allergic reaction to:

□ crown

□ metal filling

□ dental appliance

Have you ever used an Power Toothbrush? Y N

Waterpik? Y N

Are your teeth sensitive to □ Hot □ Pressure

□ Cold □ Sweets

On a scale of 1-10 (10 highest), Please indicate how important your dental health is to you.

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile, what would it be?

□ Whiter

□ Close space

□ Replace dark fillings with tooth colored restorations

□ Repair Chipped teeth

□ Replace Missing teeth

□ Replace old crowns that don't match

# PATIENT HEALTH HISTORY

| | Y | N |
|---|---|---|
| AIDS/HIV | □ | □ |
| Allergies_____ | □ | □ |
| Anemia | □ | □ |
| Arthritis | □ | □ |
| Artificial HeartValves | □ | □ |
| Asthma | □ | □ |
| Blood Disease | □ | □ |
| Cancer _____ | □ | □ |
| Chemical Dependency | □ | □ |
| Chemotherapy | □ | □ |
| Circulatory Problems | □ | □ |
| Cortisone Treatments | □ | □ |
| Cough, persistent | □ | □ |
| Diabetes | □ | □ |

| | Y | N |
|---|---|---|
| Emphysema | □ | □ |
| Epilepsy/Seizures | □ | □ |
| Excessive Bleeding | □ | □ |
| Fainting/Dizziness | □ | □ |
| Glaucoma | □ | □ |
| Headaches | □ | □ |
| Hearing Impaired | □ | □ |
| Heart lesions | □ | □ |
| Heart Murmur | □ | □ |
| Heart Problems | □ | □ |
| Hepatitis _____ | □ | □ |
| Herpes | □ | □ |
| High Blood Pressure | □ | □ |
| Jaundice | □ | □ |

| | Y | N |
|---|---|---|
| Jaw Pain | □ | □ |
| Joint Replacement | □ | □ |
| Kidney Disease | □ | □ |
| Liver Disease | □ | □ |
| Low Blood Pressure | □ | □ |
| Mitral Valve Prolapse | □ | □ |
| Neck/Back Problems | □ | □ |
| Nervous Problems | □ | □ |
| Pacemaker | □ | □ |
| Psychiatric Care | □ | □ |
| Radiation Treatment | □ | □ |
| Respiratory Problems | □ | □ |
| Rheumatic Fever | □ | □ |
| Scarlet Fever | □ | □ |

| | Y | N |
|---|---|---|
| Shortness of Breath | □ | □ |
| Sinus Problems | □ | □ |
| Skin Rash | □ | □ |
| Stroke | □ | □ |
| Swollen Feet/ankles | □ | □ |
| Swollen Neck glands | □ | □ |
| Thyroid Disease | □ | □ |
| Tonsillitis | □ | □ |
| Tuberculosis | □ | □ |
| Tumor/Growths | □ | □ |
| Ulcers | □ | □ |
| Venereal Disease | □ | □ |
| Weight change,un-explained | □ | □ |

# MEDICAL QUESTIONS

List any Medications you are taking - include nonprescription drugs:_____
_____
_____
_____

Are you allergic to □ Penicillin □ Local Anesthesia
□ Latex □ Sulfa □ Barbiturates
□ Iodine □ Aspirin □ Codeine
□ Other_____

Are you in good health? Y N

Date of last medical exam _____

Have you ever been hospitalized? Y N
if yes, please explain_____

Pharmacy_____

Do you have any disease/problem that we should know about? Y N
_____
_____

Have you had a transplant operation that has depressed your immune system? Y N

Have you had an allergic reaction to bananas? Y N

Do you smoke or use tobacco? Y N

Have you had Heart surgery? Y N

Are you currently under the care of an MD? Y N

Are you/have you ever taken bisphosphonates? Y N
(Fosamax or Actonel for osteoporosis, chemotherapy, etc)

**Women:** Are you Pregnant or Nursing? Y N
Taking birth control? Y N

**Insurance Assignment and Release**

I certify that I and/or my dependents have insurance coverage with the aforementioned insurance company(ies) and assign directly to Dr Jackson all insurance benefits if otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr Jackson may use my healthcare information and may disclose such information to the above named insurance company(ies) and there agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will remain in effect until I revoke it in writing.

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or other members of his staff responsible for any errors that I have made in the completion of this form.

Patient:_____ Date:_____

Parent/Guardian (if patient is a minor)_____ Date_____