Patient Information

Patient Name: ____ **Todays Date:** ______________

Last First MI (Preferred Name)

Gender: Female ☐ Male **Birth Date:** ____________________ **Social Security #:** ________________________________

Phone (Home): _________________________ **(Work):** ____________________ **Ext:** ______ **(Cell):** _________________________________

E-Mail Address: ______________________ **Emergency Contact:** _____________________ **Emergency Contact Phone #:** _________________

Mailing Address: ____

Street P.O. Box Apartment #

____

City State Zip Code

Health Information

Date of Last Dental Visit: ____________________ **Reason for this visit:** _____________________________________

Have you ever had any of the following? Please check those that apply:

__ AIDS	__ Excessive Bleeding	__ Liver Disease	__ Stroke
__ Allergies ________	__ Fainting	__ Mental Disorder	__ Tuberculosis
________	__ Glaucoma	__ Nervous Disorders	__ Tumors
__ Anemia	__ Growths	__ Pacemaker	__ Ulcers
__ Arthritis	__ Hay Fever	__ Pregnancy	__ Venereal Disease
__ Artificial Joints	__ Head Injuries	Due Date: _______	__ Codeine Allergy
__ Asthma	__ Heart Disease	__ Radiation Treatment	__ Penicillin Allergy
__ Blood Disease	__ Heart Murmur	__ Respiratory Fever	__ Latex Allergy
__ Cancer	__ Hepatitis	__ Rheumatic Fever	OTHER:
__ Diabetes	__ High Blood Pressure	__ Rheumatism	______________
__ Dizziness	__ Jaundice	__ Sinus Problems	______________
__ Epilepsy	__ Kidney Disease	__ Stomach Problems	______________

- Have you ever had any complications following dental treatment? ___ YES ___ NO
  - If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ___ YES ___ NO
  - If yes, please explain: ____
- Are you know under the care of a physician? ___ YES ___ NO
  - If yes, please explain: ____
- Name of Physician: ____ Phone # __________________________
- List any medication patient is currently taking or taken in the past month:_____________________________________
- List any medication patient is allergic to:____
- Do you have any health problems that need further clarification? ___ YES ___ NO
  - If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian: ____ Date: ________________

Referral Information

Whom may we thank for referring you to our practice? ___Another patient, friend ___Another patient, relative

___ Dental Office ___ Yellow Pages ___ Newspaper ___ School ___ Work ___ Other ___________________________

Name of person or office referring you to our practice: ____

Responsible Party Information

The following is for the person responsible for payment.

Name: ______________________________ **Male** **Female** ☐ **Married** ☐ **Single**

Social Security # ______________________________ **Birth Date:** ______________________

Phone (Home): ____________**(Work):** ____________ **Ext:** _______ **Cell:**____________ **Best time to Call:** ____________

Address: ____

Street **Apartment#**

____

City **State** **Zip Code**

Employment Information

The following is for the person responsible for payment.

Employer Name: ______________________________ **Phone #:** ______________________

Address: ____

Street **City** **State** **Zip Code**

Policy Holder – Dental Insurance Information

PRIMARY

Name of Insured: ______________________ **Is insured a patient?** ___ **YES** ___ **NO** **Social Security #** ______________

Insured's Birth Date: ____________ **ID #:** ____________ **Group #:** ______________________

Insured's Address ____

Street **City** **State** **Zip Code**

Insured's Employer Name: ______________________ **Patient's relationship to insured:** **Self** **Child**

Address: ____

Street **City** **State** **Zip Code**

Insurance Plan Name and Address: ______________________________ **Phone #** ______________

Street **City** **State** **Zip Code**

SECONDARY ADDITIONAL DENTAL OR MEDICAL

Name of Insured: ______________________ **Is insured a patient?** ___ **YES** ___ **NO** **Social Security #** ______________

Insured's Birth Date: ____________ **ID #:** ____________ **Group #:** ______________________

Insured's Address ____

Street **City** **State** **Zip Code**

Insured's Employer Name: ______________________ **Patient's relationship to insured:** **Self** **Child**

Address: ____

Street **City** **State** **Zip Code**

Insurance Plan Name and Address: ______________________________ **Phone #** ______________

Street **City** **State** **Zip Code**

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for the dental car can only be extended for a period of six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver or any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________________ Relationship to Patient: ____________________

Signature of parent or guardian/ guarantor of payment

Lauren B. Jones DMD Pediatric Dentistry

CONSENT FOR USE AND DISCLOSURE

OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPPAA), 1996

http://hhs.gov/ocr/hipaa/finalreg.html

Section A: Parent/Guardian Giving Consent

Name:_______________________________________

Address:_____________________________________

Telephone:_____________ Email: _______________

Social Security #:_____________________________

SECTION B: TO THE PATIENT/GUARDIAN- 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 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: Lauren B. Jones, DMD

722 Deleware Ave St. McComb, MS 39648

601-250-5907

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 the 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.

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: ______________________

Authorization for Disclosure of Health Information

Occasionally, you may find it helpful for our clinic to be able to discuss your child's health information with family members, friends or school officials. For example, someone other than you or your spouse may need to bring the child to the clinic for a visit or pick up a prescription. We will be unable to discuss your child's care or to give out a prescription to anyone else unless we have your permission to do so.

I authorize

Lauren Brock Jones, DMD

722 Delaware Ave.

McComb, MS 39648

To disclose the health information of:

Patient Name: ____

Date of Birth: _______________________________Phone: ______________________________________

Address: ____

City: _______________________________________State: ____________________Zip: ______________

To the Following individuals (list family members, friends, or school officials who may receive information about your child):

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire upon the child reaching the legal age of majority.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Jan Alexander, Privacy Officer for Lauren Brock Jones, DMD.

____ ____

Signature of parent or legal representative & Date Signature of Witness & Date

____ __________________________________

Signature of parent or legal representative & Date Signature of Witness & Date

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal Law (42 CFR, part ll).

Lauren Brock Jones, DMD

Pediatric Dentistry

Patient Policies

In order to better serve you and to provide the best possible care for your child, we ask that you be aware of and observe the following:

1. The parent (or legal guardian) of the child/patient must accompany him/her during the first visit to this office. Patients under the age of 16 years must be accompanied by a parent at each visit to the office. Unaccompanied patients must have written parental consent for each office visit.

2. Parent/guardian accompanying the child must remain on the premises during the office visit.

3. One parent/guardian may be present in the treatment area with the patient. All other family members are asked to remain in the waiting room. It is a privilege, however, for a parent to remain in the treatment area. In many cases, a child's behavior improves when the parent is not present. If Dr. Jones sees this as such a case, you will be asked to wait in the waiting room.

4. Emergency visits are worked into a very busy schedule. As a courtesy to our patients with regularly scheduled appointments, you may have a longer wait time in this case.

5. If a patient is more than 10 minutes late for an appointment, he or she might not be seen or may have to wait until an opening in the schedule occurs.

6. Only an exam, radiographs, and a cleaning/fluoride are routinely done on the first appointment. If Dr. Jones sees that there is an emergency that needs to be addressed immediately, it is at her discretion to decide if further treatment will be rendered on the first appointment.

I have read and understand the above patient policies and agree to abide by them.

____ Date ____________________

FINANCIAL AGREEMENT

1. As your child's dental provider, we want to provide your child the best care possible. There may be certain services that your child's insurance company does not cover that we deem necessary**. Therefore, it is your responsibility to know your benefits. By signing this form, your stating that you will be responsible for payment of all services not covered by your child's insurance at time of service. You understand that your child's Medicaid or CHIPS insurance does not cover the following fees and you will be responsible for payment of these fees at the time of service. The fees not covered are nitrous oxide (gas), versed sedative, re-cementation or replacement of crown(s) and re-cementation or replacement of any space maintainer(s).**

2. If your child has any appliance(s) or crown(s) placed and it comes off within 48 hours, this will be re-cemented at no additional charge. However, if this happens after 48 hours, you will be financially responsible for the charges if your child's insurance does not cover the service. If the child loses or breaks the appliance or crown, you are responsible for the replacement as this service is not covered by insurance.

3. Co-payments or deductibles are due at the time of service. A deposit for services may be required for certain procedures and will be applied to the service rendered.

4. If the patient requires surgery at the hospital, a **$25 surgery deposit** must be paid prior to scheduling surgery. The treatment plan must be paid in full prior to surgery.

5. The parent or guardian is responsible for maintaining the child's insurance coverage; this includes Medicaid or CHIPS coverage. If the child becomes inactive, the parent or guardian will be responsible for payment of all services and treatment rendered. If the child's insurance coverage changes it is the responsibility of the parent or guardian to inform the office of these changes or you will be liable for all charges that are not paid.

6. **Divorced or Separated Guardian:** Children of divorced or separated parents should be accompanied by the financially responsible parent. In the case whereby distance makes this impossible, the adult accompanying the child shall sign the financial responsibility agreement and agree to pay our office and thereby assume the responsibility to collect all monies from their ex-spouse. Our office will not make any attempt to collect payment from a parent that is not present in the office at the visit. We will not act as a medium in any way when dealing with divorced or separated families.

7. As a specialist's office, we request that cancellation of a scheduled appointment be done **at least 24 hours** before the scheduled appointment. Without adequate notice, we cannot fill your appointment time with another patient. If we are not in the office when you see you cannot make the appointment, please leave a message on the machine. A **$30 cash or debit rescheduling fee** will be charged for any appointment for which the child misses or does not give 24 hours cancellation notice. This fee must be paid prior to being placed back on the schedule. **This applies to all patients and is not covered by any insurance company including Medicaid.**

8. For emergency visits after regular office hours will be provided at a fee of **$150** in addition to the fee for the service or treatment rendered. This payment is due at the time of service.

9. There is a **$40 cash or debit fee** for all returned checks.

10. A **10% late fee** will be added to your balance if payment is not received within 30 days of the statement date.

11. If you maintain a balance on your account for more than 30 days without any form of payment and costs are incurred for collections, **you will be responsible for all collection fees.**

I have read and understand the above financial policies and agree to abide by them.

Form completed by:

Name: ______________________________________ **Signature:** ____

Relationship to child: ____ **Date:** ____________________________

Are you the person legally responsible for the child? **YES** _______ **NO**_______

Reviewed by staff member: ____ **Date:** ____________________________