PATIENT INFORMATION

JACKSONVILLE COMPLETE DENTISTRY

Today's Date _____/_____/_____

Patient's Name _____
First MI Last

Please let us know if you have a nickname or preferred name by which you wish to be called. _____

Sex ☐ M ☐ F Date of Birth _____/_____/_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address _____
Street City State Zip

Phone # (_____) _____ (_____) _____ (_____) _____
Home # Work # Ext# Mobile #

Social Security # _____ E-mail Address _____
(**Please note**- if you choose not to provide your SS#, we must collect the full payment- in the form of cash- at each visit and cannot bill your insurance carrier on your behalf. However, we are happy to print a claim that you may submit to your insurance carrier for reimbursement.)

What is your preferred method of contact regarding your upcoming dental appointments? Text ☐ / Email ☐ / Phone Call ☐

Employer _____
Name Address City State Zip

Has any member of your family been treated in our office? ☐ Yes ☐ No If so, who? _____

Contact in case of emergency _____ (_____) _____
Name Relationship Phone #

☐ Spouse *or* ☐ Parent, if minor _____ (_____) _____
Name Address Phone #

Person Responsible for Account _____
Name Relationship SS#

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card *or* please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union #, if any _____

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs.

Patient, Parent or Guardian Signature _____
Date _____

MEDICAL HISTORY

JACKSONVILLE COMPLETE DENTISTRY

Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Are you under a physician's care now? ☐ Yes ☐ No If so, for what? _____

_____

Physician's Name _____ Phone # (_____) _____

Are you taking (or supposed to be taking) any medications, vitamins or herbal supplements? ☐ Yes ☐ No Please list below

_____

_____

Are you pregnant? ☐ Yes ☐ No If yes, due date _____

Do you use tobacco in any form? ☐ Yes ☐ No _____

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or alendronate? ☐ Yes ☐ No

Are you allergic to any medications or substances? ☐ Yes ☐ No If yes, please check boxes below.

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine

☐ Latex or Rubber ☐ Other _____

Have you ever had a reaction or experienced complications to any dental treatment in the past? ☐ Yes ☐ No

Please check "yes" if you presently have or have had in the past any of the following conditions:

Yes		Yes		Yes	
☐	Heart Trouble/Disease	☐	Lung or Breathing Problems	☐	Severe Headaches
☐	Heart Murmur*	☐	Shortness of Breath	☐	Fainting or Dizzy Spells
☐	Irregular Heart Beat	☐	Sinus Trouble	☐	Epilepsy, Seizures or Convulsions
☐	Angina or Chest Pain	☐	Asthma	☐	Psychiatric Care
☐	Heart Attack or Failure	☐	Chronic Cough	☐	Hepatitis, Jaundice or Liver disease
☐	Congenital Heart Disorder	☐	Emphysema	☐	Arthritis, Gout or Rheumatism
☐	Mitral Valve Prolapse*	☐	Tuberculosis (TB)	☐	Artificial Joint*
☐	Rheumatic Fever*	☐	Frequent Sore Throat	☐	Night Sweats
☐	Artificial Heart Valve*	☐	Tumor or Cancer	☐	Stomach or Intestinal Disease
☐	Heart Pacemaker*	☐	X-ray or Cobalt Treatment	☐	Thyroid Disease
☐	Heart Surgery	☐	Chemotherapy	☐	Kidney or Bladder Problems
☐	Stroke	☐	Enlarged Lymph Nodes (Glands)	☐	Renal Dialysis
☐	Aneurysm	☐	Swelling of Limbs	☐	Hypoglycemia
☐	High Blood Pressure	☐	Bruise Easily	☐	Frequent Diarrhea
☐	Low Blood Pressure	☐	HIV Positive or AIDS	☐	Glaucoma or Eye Problems
☐	Bleeding Disorder	☐	Sexually Transmitted Diseases	☐	Excessive Thirst
☐	Blood Transfusion	☐	Major surgery	☐	Diabetes

_____

Have you ever had any other disease, problem or condition not listed above? ☐ Yes ☐ No Discuss _____

_____

Do you wish to speak privately to the dentist about any problems? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____

JACKSONVILLE
COMPLETE DENTISTRY

7740 Point Meadows Drive
Suite #4
Jacksonville, FL 32256
(904) 645-6457

REGARDING PATIENT PRIVACY

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more 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 from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

JACKSONVILLE
COMPLETE DENTISTRY

VELscope Vx
Oral Cancer Assessment

Our office recommends and uses VELscope oral cancer assessment testing. Early detection is a key to survival. Alarmingly, 25% of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age, tobacco and alcohol use.

The VELscope testing is in addition to our traditional visual oral cancer screening and will only add a few minutes to the entire exam. However, the VELscope exam may or may not be covered by your insurance.

The fee for this enhanced examination is only **$25.00**. As part of our standard or care- and because we care about you- we strongly recommend that you choose this additional screening procedure.

At your hygiene appointment today, you will be asked:

Yes, I accept VELscope _____

No, I decline VELscope _____

Fluoride Treatment

The benefits of fluoride are extremely valuable to your dental enamel. Everyone benefits from fluoride, especially children between the ages of 6 months and 16 years because this is the timeframe during which the primary and permanent teeth come in. It is also imperative for adults to help prevent sensitivity and decay, which can be caused by the demineralization of enamel from the acids and sugars found in food and drinks consumed daily. The continuous benefits of fluoride have been proven to strengthen enamel and aid in the prevention of cavities.

The fee for this enhanced service is only **$17.00** if the benefit is not covered by your insurance. This is recommended once every 6 months for cavity prevention at your routine cleanings.

At your hygiene appointment today, you will be asked:

Yes, I accept Fluoride _____

No, I decline Fluoride _____

Date: _____ Print Name:_____

Signature: _____

JACKSONVILLE
COMPLETE DENTISTRY

Broken Appointment Policy

We have more patients who need dental care than we often have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who desperately needs dental care. This policy is our attempt to ensure that both you and other patients receive the dental care that is needed.

Broken Appointments: Patients are only allowed ONE broken appointment in a 12 month time period.

- Broken appointments are any time you are scheduled for an appointment and you do not show for that appointment.
- Late cancellations are considered broken appointments. If you need to cancel your appointment, we ask that you please call us at least 24 hours before your appointment time.

Appointment Confirmation: Our practice uses automatic confirmation for appointments. Email, text, or phone reminders are sent for appointments for confirmation. It is important to respond to these so we can be sure to see all patients for their allotted appointment.

If for any reason, a patient misses their appointment or cancels late for a second time within a 12 month period, they will not be scheduled for another appointment. However, these patients are still welcome to receive dental care from us. Patients who have broken multiple appointments can call us in the morning for a “same day appointment” provided there is an opening somewhere in the schedule.

Patient Signature