486 Andrews Avenue
Ozark, Alabama 36360
(334) 774-5952
www.jenningsdental.net

Welcome to Our Office!

To help us meet all your dental care needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Date ______________________

Full Name __________________________ Preferred Name________________ Status: Single / Married
Soc. Sec. #_______________________ Birth Date ________________________ Gender: Male / Female
Address______________________________City______________State__________Zip __________
Email _______________________________________ Drivers License #________________________
Home Phone _____________________Cell #____________________Work #____________________
Person to contact in case of emergency __________________________ Phone_____________________

Responsible Party (If under age of 19)

Name of person responsible for this account_____________________ Relationship to patient ___________________
Contact #_____________________ Birth Date _______________ Drivers License_________________
Employer _____________________________Work phone_____________ SSN# _________________

*** Any phone number given on this form or in the future to our office, is giving expressed consent to allow our office and it's agents to contact you on any/all phone numbers, including but not limited to cell phones, text messages and email for all purposes of treatment, insurance, and payment.

Insurance Information

Primary Insurance _________________________Group #__________Contract #__________________
Name of Insured ___________________Birth Date _________________SSN ____________________
Employer________________________________ Work phone ________________ext:_____________

Secondary Insurance_______________________Group#_____________Contract#________________
Name of Insured ___________________Birth Date __________________SSN ___________________
Employer________________________________ Work phone _________________ext:____________

Patient Dental History

Previous Dentist _________________________ Date of last cleaning/exam_______________________
Reason for leaving ____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain with any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐

	Yes	No
9. Have you experienced any of the following problems with your jaw?		
--Clicking	☐	☐
--Difficulty in opening or closing?	☐	☐
--Difficulty with chewing	☐	☐
--Pain (joint, ear, side of face)	☐	☐
10. Have you ever had difficult extractions in the past?	☐	☐
11. Have you experienced prolonged bleeding following extractions?	☐	☐
12. Do you wear dentures or partials?	☐	☐
13. Do you like your smile?	☐	☐

Patient Medical History

Physician______________________Office Phone___________________ Date of last exam___________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness in the past 5 years? If yes, please explain ______________________ ____	☐	☐
3. Are you taking any medications including non-prescription medicine? (Please list) ____ ____	☐	☐
4. Are you currently taking or have you ever taken osteoporosis medications? If so, how long? __________________________ Which ones? _____________________________	☐	☐
5. Do you use tobacco products?	☐	☐
6. Do you use controlled substances or recreational drugs?	☐	☐

7. **Are you allergic to:**	Yes	No
Local Anesthetic	☐	☐
Penicillin	☐	☐
Codeine	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Ibuprofen	☐	☐
Tylenol	☐	☐
Latex	☐	☐
Jewelry / metals	☐	☐
Other: ______________________		

8. **Women Only**	Yes	No
a.) Are you pregnant?	☐	☐
b.) Are you nursing?	☐	☐
c.) Do you currently take birth control pills?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Pacemaker	☐	☐	Hay Fever / Allergies	☐	☐
Low Blood Pressure	☐	☐	Heart Murmur	☐	☐	Abnormal Bleeding	☐	☐
Heart Attack	☐	☐	Anemia	☐	☐	Alcohol / Drug Abuse	☐	☐
Mitral Valve Prolapse	☐	☐	COPD	☐	☐	Fever Blisters	☐	☐
Fainting	☐	☐	Tuberculosis	☐	☐	Psychiatric Problems	☐	☐
Seizures	☐	☐	Asthma	☐	☐	Headaches	☐	☐
Cancer __________	☐	☐	Arthritis	☐	☐	Sinus Problems	☐	☐
Diabetes	☐	☐	Liver Disease	☐	☐	Artificial Joints / Valves	☐	☐
HIV / AIDS	☐	☐	Stroke	☐	☐	Hepatitis / Jaundice	☐	☐
Thyroid Problems	☐	☐	Rheumatic Fever	☐	☐	Sexually Trans. Disease	☐	☐

Scheduling Routine Appointments:

Your hygienist automatically schedules your 6 month checkup after every dental cleaning. You will receive several reminders 1 month prior including postcard, email, text and phone calls. If you do not wish to have your appointment automatically scheduled, please be sure to tell your dental hygienist.

Missed Appointment Fee

Missed appointments greatly affect a small business like ours. When a patient does not call to cancel or reschedule, it is a missed opportunity, not only financially, but also for other patients waiting for appointments.

A) All patients who do not cancel or reschedule a routine cleaning appointment 24 hours prior to the scheduled appointment will be charged a $25.00 fee that is not covered by any insurance, including Medicaid and VA, and will be billed directly to the patient or guardian.

B) All other appointments for services OTHER THAN routine cleanings will be charged $50.00 if not canceled or rescheduled 24 hours prior to scheduled appointment time. This fee is not covered by any insurance, including Medicaid and VA, and will be billed directly to the patient or guardian.

C) Patients that miss multiple appointments will be dismissed from the practice.

Financial Responsibility

I understand that I am responsible for payment of services rendered and responsible for paying any and all co-payments and deductibles that my insurance does not cover at time services are rendered. In the event that account is turned over to collections, the undersigned accepts this balance as a lawful debt and promises to pay said fee as outlined above including collection agency fees of 33.33%, attorney fees and court costs if such be necessary.
Refusal to sign this form will result in total balance to be paid in full at time of service (cash or credit/debit card only) and you will be responsible for filing your dental insurance claim.

Accepted Payment Methods

Cash, Debit card, Visa, Mastercard, American Express, and Discover cards are all acceptable as payment. Checks are accepted, but cannot be held for a future deposit date. There are no exceptions. Checks are NOT accepted for new patients. Maximum fee allowed by law will be charged on all returned checks. In the event of a returned check, all future payments for entire account will be cash or credit/debit card only.
All funds received by Dr. John A Jennings, DMD, PC via finance company (Care Credit) will be subject to a 10% administrative fee (i.e., $5000 case would result in a $500 administrative fee). Once the treatment plan is completed and insurance has paid, any remaining credit can only be refunded directly to the original financial company. Our office has up to 30 days to refund the balance.

Insurance Agreement

We file to many insurances as a courtesy to our patients. You may request to pay our office in full and file your insurance claims directly. Would you prefer our office to file your claim?
☐ Yes ☐ No
If you request our office to file please be aware of the following:

1. All estimated out-of-pocket expenses and deductible are due when services are rendered. No exceptions.
2. Services are not based on what insurance pays, but on what Dr. Jennings feels is necessary. Insurance can refuse to pay for any service at any time. They may also downgrade on any service. It is your responsibility to tell us if your policy downgrades work, has waiting periods, or any other idiosyncrasies so that we may give you an accurate quote. Please feel free to bring in your policy booklet.
3. It is your responsibility to tell us if there are any changes in your dental insurance(s). If we file an insurance that is no longer active and it is denied, you will be billed for the full amount owed.
4. We do our best to give accurate quotes, however, they are not a guarantee of the patients out-of-pocket expenses. Ultimately, the patient or guardian of patients 18 years of age and under will be responsible for any and all charges not covered by insurance on work that is completed. The unpaid balance will be billed to the patient and is expected promptly. You may request us to file a pre-determination to your insurance.
5. This office is only aware of the amount of dental insurance used here. During a quote for dental work, it is the patient’s responsibility to notify the office staff of any possible insurance used at another dental office because it may change your our-of-pocket expense.
6. We only check your eligibility for x-rays on your first visit to our office. This means if you visit another dental office and they take routine x-rays, you need to let us know and bring a copy to our office to avoid any overlap. Insurance carriers usually pay once every 3-5 years for panoramic films and once for bitewings depending on your dental carrier.

In the event this form is being filled out for a minor (age 18 and under), the parent/guardian who signs this form is ultimately responsible for the minors account.
I have read, understand and agree to all the above statements.

Signature________________________________ Date____________________

Printed Name______________________________

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Acknowledgement of Receipt of Notice of Privacy Practice

HIPPA

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named dental practice's Notice of Privacy Practice.

Is there anyone other than the parent/spouse who we may speak with regarding dental appointments and/or treatment?

Name______________________________________Relationship_________________

Name______________________________________Relationship_________________

Name______________________________________Relationship_________________

Name______________________________________Relationship_________________

Signature____________________________________
Printed Patient name____
Date____