John Jennings Dental Health and Beauty

486 Anrews Avenue Ozark, AL 36360

(334) 774-5952

Patient Information Date: _____

Full Name: _____ Preferred Name: _____

Status: Single / Married SSN#:_____ Birth Date: _____

Gender: Male / Female Email:_____

Address:_____City:_____State_____Zip:_____

DriversLicense#: _____ Home #: _____

Cell #: _____ Work #: _____

Emergency Contact: _____ Phone:_____

Responsible Party (If under the age of 19)

Name of person responsible for account: _____

Relationship to patient: _____ Contact #: _____

Birth Date: _____ Driver's License #: _____ SSN#: _____

Employer: _____ Work phone: _____

*** Any phone number given on this form or in the future to our office, is giving expressed consent to allow our office and its 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: _____

Secondary Insurance: _____ Group #: _____

Contract #: _____ Name of Insured: _____

Birth Date: _____SSN: _____

Employer: _____ Work phone: _____

Patient Medical History

Physician: _____ Office Phone: _____

Date of last exam: _____

1. Are you under medical treatment now? Yes or No
2. Have you been hospitalized for any surgical operation or serious illness in
   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? Yes or No
   If so, how long? _____

Are you allergic to: Circle one

Local Anesthetic
Penicillin
Codeine
Sedatives
Aspirin
Ibuprofen
Tylenol
Latex
Jewelry / metals
Other: _____

Medical History: Circle One

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 (Type 1 or 2)	Liver Disease	Artificial Joints / Valves
HIV / AIDS	Stroke	Hepatitis / Jaundice
Thyroid Problems	STD	Rheumatic Fever

Scheduling Routine Appointments:

Your hygienist automatically schedules your 6-month checkup after every dental cleaning. You will receive several reminders 1 month prior including 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 all co-payments and deductibles that my insurance does not cover at time services are rendered. If the 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 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. 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 or 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.
3. **It is your responsibility to tell us if there are any changes in your dental insurance(s). If we file to your insurance that is no longer active and it is denied, you will be billed for the full amount owed.**
4. 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 out-of-pocket expense.
5. We only check your eligibility for x-rays on your first visit to our office. This means if 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 minor's account. I have read, understand, and agree to all the above statements.

Signature: _____ Date: _____

Printed Name: _____

Acknowledgement of Receipt of Notice of Privacy Practice

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_____

Signature: _____
Printed Patient name: _____
Date: _____