Ashley Jackson DDS PLLC

E-Mail: ajacksondds@tylerfamilydentist.com **Phone: 903-593-2313**
1211 Clinic Drive **Fax: 903-597-7033**
Tyler, TX 75701 **Website: TylerFamilyDentist.com**

Patient Information

Patient Name: _____ Date: _____
Last First MI
Preferred Name: _____
□ Male □Female □Married □Single □Child □Other _____

Social Security #: _____ Birth Date: _____ Age: _____
Home Number: _____ Work Number: _____ Ext: _____
Cell Number: _____
Address: _____
Street Apt #
_____
City State Zip Code
E-mail Address: _____
Employer: _____ Occupation: _____

Responsible Party Information (If different than patient):
If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody.

Name of Person Responsible for this Account: _____
Relationship to Patient: _____ Social Security #: _____
Birth Date: _____
Home Number: _____ Work Number: _____ Ext: _____
Cell Number: _____
Address: _____
Street Apt #
_____
City State Zip Code

Former Dentist: _____ City/State: _____
Date of Last Dental visit: _____ Reason for today's visit: _____
Date of Last Cleaning: _____ Date of last dental x-rays: _____
How often do you floss? _____ How often do you brush? _____
Was your pattern of visits: □ regular □ infrequent □ sporadic

Whom may we thank for referring you to our practice?
Patient, Friend/Relative_____ Website/Internet Other_____

In case of emergency, please list a friend or family member not in your same household:
Name: _____ Home Number: _____
Work Number: _____ Cell Number: _____

Medical History:

List medications you are currently taking: _____

_____

_____

Pharmacy Name: _____

Have you ever had any complications during or 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 now under the care of a physician? ☐ Yes ☐ No
Name of primary physician: _____
Name of any other physicians: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Are you using any recreational drugs? ☐ Yes ☐ No

Are you accustomed to regular dental cleanings and check-ups? ☐ Yes ☐ No

Are you happy with the appearance of your smile? ☐ Yes ☐ No

Do you wish to be shown how we can improve the look of your smile? ☐ Yes ☐ No

Do you expect to keep your teeth for your lifetime? ☐ Yes ☐ No

What do you expect most from your dentist? _____

Please list any other pertinent information you need us to know to better serve your dental needs: _____

_____

Are you allergic to or have you had any reactions to the following?

☐ ☐Aspirin ☐Local Anesthetic ☐Codeine ☐ ☐Penicillin
☐ ☐Sulfa ☐Latex ☐Other_____

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

☐AIDS
☐Anemia
☐Arthritis/Rheumatism
☐Artificial Joint/Valves
☐Asthma
☐Autoimmune Disease: _____
☐Blood Disease
☐Chemical Dependency
☐Chemo Date: _____
☐Circulatory Problems
☐Diabetes Type ____
☐Dizziness/Fainting
☐Emphysema
☐Epilepsy
☐Excessive Bleeding
☐Fibromyalgia
☐Head Injury
☐Heart Murmur
☐Heart Problems/Disease
☐Hepatitis Type ____
☐Herpes
☐High Blood Pressure
☐HIV
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Low Blood Pressure
☐Lung/Respiratory Disease
☐Lupus
☐Mental Disease
☐Mitral Valve Prolapse
☐Multiple Sclerosis
☐Nervous Disorder
☐Osteoporosis
☐Pace Maker
☐Pregnant at THIS time
Due Date: _____
☐Premed Needed
☐Psychiatric Care
☐Radiation Date: _____
☐Rheumatic Fever
☐Sinus Problems
☐Stroke
☐Swelling of Feet/Ankles
☐Swelling of Neck Glands
☐Taken Bisphosphonates
☐Thyroid Problems
☐Tuberculosis
☐Tumors/Growths
☐Venereal Disease

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

☐Bad Breath
☐Chew on Side of Mouth
☐Clench/Grind Teeth
☐Clicking or Popping Jaw
☐Dry Mouth
☐Food Collection between Teeth
☐Jaw Pain or Tiredness
☐Loose Teeth/Broken Fillings
☐Orthodontic Treatment
☐Pain Around Ear
☐Periodontal Treatment
☐Radiation to Head/Neck
☐Sensitivity to Cold
☐Sensitivity to Hot
☐Sensitivity to Pressure
☐Smokeless Tobacco
☐Sores/Growths in Mouth
☐Swollen or Tender Gums
☐TMJ Treatment
☐Tobacco Usage

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 doctor at the next appointment without fail.

_____ _____
Signature of Patient or Guardian Date

FINANCIAL AGREEMENT

We are happy to assist you in verifying your benefits and maximizing them to your fullest financial advantage. We will assist you in preparing forms or printing receipts for you to file with your insurance company; or if we file insurance claims on your behalf, we will need a copy of your current insurance card; you are required by your insurance company to pay all co- pay's, coinsurance, and deductibles which are due and payable at the time of service.

Verification of your insurance does not guarantee payment. Payment is subject to review by your insurance company and is determined upon the actual receipt of the claims by the insurance company. Dr. Jackson's office will file an initial insurance claim on my behalf at no additional cost. If my insurance carrier has not responded or denies payment within 45 days of the date of the service the entire fee for the service is due and payable by me. I understand any remaining balance regardless of the amount of the insurance payment is my responsibility and it is my responsibility to contact your insurance company to dispute any denial, or nonpayment issues.

Authorization to pay benefits to dentist: I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

I, _____, understand that any service performed for my dependant or me by Dr. Jackson or her office is my personal financial responsibility. If I have dental insurance I understand that it is not Dr. Jackson's office responsibility to collect from my insurance company. I, the insured/dependant, have read the above and understand the policies regarding office financial and insurance policies. I agree to comply with all policies and agree to be responsible for payment of all services at the time rendered.

_____

Signature of Patient or Guardian Date

CANCELLATION POLICY

I understand that I need to arrive at the appropriately scheduled time for treatment. The doctor and hygienist have numerous duties encompassed by their schedule. Therefore, the facility asks that you arrive at your appropriately scheduled time.

- Arriving excessively early will not ensure or entitle you to begin your appointment early.
- Likewise, tardiness in excessive of 15 minutes may require rescheduling of the appointment or modification of your treatment. We do our best to run on time. The nature of our practice is to give our patients the utmost care and service. Please excuse any delays on our part. We will give you the same careful attention as soon as possible.
- In the event that you do need to cancel or anticipate being late- please call us at (903)593-2313 before your scheduled treatment time. We request a 24-business hour notice for all cancellations. Failure to do so may be subject to a $50.00 charge.

The schedule is available by first come first serve basis. Canceling minutes or hours before an appointment or not showing for an appointment may prevent other patients from scheduling. Again, we request a 24-business hour notice for all cancellations; otherwise you will be subject to a $50.00 charge. Excessive abuse of the schedule, arriving late (more than 15 minutes) or not showing up three (3) or more times may result in dismissal from our office. We will try out very best to accommodate your schedule within our available resources. Your assistance and understanding is appreciated.

_____

Printed Name

_____ _____

Signature of Patient or Guardian Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Print PATIENT Name | Signature of Patient or Guardian

_____ _____

Print GUARDIAN Name | Relationship of Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN CALLED BACK FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sur Name ☐ Other_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone ☐ Work Phone

☐ Home Phone ☐ **Any of the Above**

I AUTHORIZE ADDITIONAL METHODS OF CONTACT VIA:

☐ Text ☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY- *(do not fill out)*

As Privacy Office, I attempted to obtain the patient's (or representative) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

Other Please describe: _____ _____

Signature of Privacy Officer