WELCOME TO OUR PRACTICE

PATIENT _____
Last Name First Name Middle Initial Preferred Name

Street Address _____City_____State_____Zip_____

Cell Phone_____Home Phone_____Email_____

Sex_____Birthday_____Social Security #_____Marital Status_____

Employer_____Work Phone_____Occupation_____

In case of an emergency, who should be notified?_____Phone_____

RESPONSIBLE PARTY _____
Last Name First Name Middle Initial

Street Address _____City_____State_____Zip_____

Cell Phone_____Home Phone_____Email_____

Sex_____Birthday_____Social Security #_____Marital Status_____

Employer_____Work Phone_____Occupation_____

REFERRAL SOURCES

Please let us know who referred you to us or how you heard about our practice. As a special thanks to our patients, we will credit $25 to their account for each patient referred. *Referral source or patient name:*_____

DENTAL INSURANCE INFORMATION

Name of Insured_____
Last Name First Name Middle Initial

Birthday_____Social Security #_____Employer_____

Insurance Carrier_____Phone_____Group #_____

MINOR/CHILD CONSENT

I, being the parent or guardian of_____(Name of Minor/Child) do hereby request and authorize the dental staff to perform necessary services for my child, including but not limited to X-rays, and an administration of anesthetic which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Patient, Parent or Guardian Signature_____Date_____

STAFF USE ONLY

Photo ID Verified	ID#/Type	State	Exp. Date

JL DENTAL

DENTAL HISTORY AND CONCERNS

JL Dental focuses on providing comprehensive care to adults and their families. We look beyond just the teeth and gums, treating the whole patient, comprehensively. We seek to establish a harmonious relationship of the three main factors affecting your bite – teeth, muscles, and jaw joints. An optimal bite is also essential to ensure that smile makeovers and dental restorations are beautiful, functional, and long-lasting.

What is the main purpose for your visit today?_____

Does floss shred when you use it? **Yes** **No** Does food pack or catch between your teeth? **Yes** **No**

Do you smoke or chew tobacco? **Yes** **No** Do your gums bleed? **Yes** **No** Does your breath concern you? **Yes** **No**

Are you interested in learning how we may be able to straighten your teeth? **Yes** **No**

When was your last dental appointment and cleaning?_____

How would you rate your smile (Lowest) 1 2 3 4 5 6 7 8 9 10 (Highest)

Should you need treatment, at what point should we address it? (circle one)

When my tooth hurts or breaks When something is getting worse Before a problem occurs

Please indicate if you have any of the following concerns (check all that apply):

_ My teeth are not in alignment _ I have spaces I don't like _ I do not like the color of my teeth

_ Chipped Teeth _ Protruding teeth _ Hidden or missing teeth

_ Old fillings, veneers, or crowns _ TMJ Disorder _ Overall appearance of my smile

Have you ever been told, or are you aware that you snore? **Yes** **No**

Are you interested in sedation dentistry? **Yes** **No**

What is the reason for trying a new dental office?_____

_____

Are there any additional concerns you would like us to know?_____

_____

_____

MEDICAL HISTORY

Although as dentists we treat the area in and around the mouth, it is a part of your entire body. Medical health problems that you may have or medications that you may be taking could be important to your dental health. Thank you for thoroughly answering the following questions.

Family Physician_____ Phone_____

Are you taking any medication now, including regular dosages of aspirin? Yes No

If so, please list name and dosage_____

_____

Are you aware of having an allergic reaction to any medication or substance? Yes No

If so, please list (e.g. Latex, penicillin, iodine)_____

Have you ever had heart surgery, heart valve or joint replacement? Yes No

If so, when?_____

Do you or have you ever taken Fosamax or any other biphosphonate, Zometa, Aredia, Boniva, or Actonel? Yes No

Women: Are you? _ Pregnant _ Nursing _ Taking birth control pills

Indicate which of the following you have had, or have at present.

Heart Concerns	Yes	No	Neurological Disorders	Yes	No	Headaches	Yes	No
Congenital Heart Disease	Yes	No	Osteoporosis	Yes	No	Limited Mouth Opening	Yes	No
Heart Murmur	Yes	No	Liver Disease/jaundice	Yes	No	Ringing Ears	Yes	No
High Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No	Facial Pain	Yes	No
Mitral Valve Prolapse	Yes	No	Asthma	Yes	No	Sensitive Teeth	Yes	No
Artificial Heart Valve	Yes	No	AIDS/HIV	Yes	No	Difficulty Swallowing	Yes	No
Pacemaker	Yes	No	Stroke	Yes	No	Tingling in arms/fingers	Yes	No
Latex Allergy	Yes	No	Angina	Yes	No	Jaw Clicking/Popping	Yes	No
Artificial Joints	Yes	No	Anemia	Yes	No	Dizziness	Yes	No
Kidney Trouble	Yes	No	Ulcers	Yes	No	Posture Problems	Yes	No
Radiation/Chemotherapy	Yes	No	Tuberculosis	Yes	No	Trigeminal Neuralgia	Yes	No
Epilepsy/Seizures	Yes	No	Arthritis	Yes	No	Bell's Palsy	Yes	No
Hepatitis	Yes	No	Difficulty Chewing	Yes	No	Jaw Pain	Yes	No
Psychiatric Disorders	Yes	No	Insomnia/Nervousness	Yes	No	Congested Ears	Yes	No
Diabetes	Yes	No	Teeth Clenching/Grinding	Yes	No	Loose Teeth	Yes	No
Thyroid Disorder	Yes	No	Snoring/Sleep Apnea	Yes	No	Neck Ache	Yes	No

Any other health issues_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify JL Dental doctors' of any change in health or medication.

Patient, Parent or Guardian Signature_____Date_____

FINANCIAL POLICY AND PAYMENT OPTIONS

Our mission is to deliver the best and most comprehensive dental care, and financial considerations should not be an obstacle in fulfilling your need. Therefore we provide a range of payment options for our patients.

CHECK, DEBIT CARD, VISA, MASTERCARD, OR DISCOVER CARD

Payment is due at the time services are rendered.

A 5% courtesy discount is given to patients who pay in full for their treatment with cash, check, debit/credit card prior to completion of care for treatment plans in excess of $1,000.00 out of pocket.

DENTAL PAYMENT PLANS

Flexible monthly payment plans are available for treatment from a third party company (Care Credit), subject to credit approval. We are able, in many instances, to obtain credit approval even if you have a limited or negative credit history.

Credit check permission: If you are interested in paying for treatment in monthly installments, please initial below to give your authorization to JL Dental and the financing company to check your credit history as necessary for the purpose of obtaining and maintaining your credit. **Initials_____**

INSURANCE PLANS

We accept most dental plans and we will work to maximize your dental benefits and submit your insurance claims at no charge. For your convenience, we accept the insurance benefit directly from your insurance company, and only the estimated portion not covered by your insurance is due at the time treatment is performed. However, we make no guarantees of your insurance reimbursement, and if we do not receive payment in full from your insurance company within 60 days, you will be responsible for the unpaid insurance portion.

PLEASE NOTE

We require payment of financial arrangements before the start of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

A 24-hour notice is required to change a scheduled appointment. A scheduled appointment is an agreement that JL Dental has with a patient to reserve a treatment room and to allocate time to help a patient remedy a dental condition. If this agreement is broken by the patient, a fee may be charged at the discretion of the office. Late cancellations and failed appointments may be charged up to $50 per hour for the hygienist and $100 per hour for the dentist.

In the event of a returned check, a $25 service charge will be assessed.

In the event of non-payment, you will be responsible for any collection and legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency.

I have read the financial policy in its entirety and I understand and agree to all its terms.

Patient, Parent or Guardian Signature_____date_____
(Must be 18 years or older to sign)