

Jeffrey V. Jones, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available and will be given upon request.

We reserve the right to change our privacy practices described as in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of privacy Practices, which will contain the changes. Those changes may apply to many of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please read and understand that revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I authorize Dr. Jones and staff to send recall and appointment notices by postcard____initials

Name (Please Print)

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCAION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

OUR POLICY OF CARE AND PAYMENT

The goal of our office is to deliver the finest treatment possible today, performed to your satisfaction. Fees are due when services are rendered. Dr. Jones' Dental Office will file my insurance for me. However, in the event my insurance does not pay my bill within sixty days I will accept full responsibility for my account balance. **Estimates quoted to me by this office are only estimates determined from my insurance policy, and do not represent the actual insurance payments.**

PAYMENT OPTIONS: (Please circle one below)

1. **Cash or check**
2. **MasterCard/Visa, American Express, and Novus(Discover)**
3. **Monthly Payments (CareCredit, Pulse Care)**

Approval for monthly payments only take a few minutes and we will be glad to process you application immediately. There is no cost to apply and payments can be as low as 3% of the outstanding balance. There is also an interest free option. **When you are approved for CareCredit or Pulse Care we do not require payment today.**

I UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL ARRANGEMENT. I TAKE FULL RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT. ALL BALANCES OVER 60 DAYS WILL BE CHARGED 1.5% INTEREST PER MONTH. I ALSO UNDERSTAND THAT A 24 HOUR NOTICE IS NEEDED TO AVOID BEING CHARGED FOR A MISSED APPOINTMENT. I AM RESPONSIBLE FOR KNOWING WHAT MY INSURANCE BENEFITS AND LIMITATIONS ARE. I AM AWARE THAT I AM RESPONSIBLE FOR PAYING THE FULL BALANCE IF INSURANCE HAS NOT PAID WITHIN 60 DAYS OF TREATMENT.

SIGNED: _____ DATE _____

DENTAL HEALTH FORM

NAME _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

YES NO

- ___ ___ Are you missing teeth?
- ___ ___ If yes, have they been replaced?
- ___ ___ Are you happy with your replacement?
- ___ ___ Do you clench or grind your teeth?
- ___ ___ Swelling or gum boils?
- ___ ___ Frequent headaches or facial pains.
- ___ ___ Difficulty in opening or closing jaw.
- ___ ___ Teeth sensitive to sweets, hot or cold.
- ___ ___ Bleeding gums when brushing.
- ___ ___ Food catches between teeth.
- ___ ___ Soreness or jaw pains.
- ___ ___ Bad breath.
- ___ ___ Unpleasant taste.
- ___ ___ Unfavorable dental experience.
- ___ ___ Problems with wisdom teeth.
- ___ ___ Orthodontic treatment.
- ___ ___ Loose teeth.
- ___ ___ Do you like your smile?
- ___ ___ Would you like whiter teeth?

What did you have done at your last dental visit? _____

Do you feel your teeth are in good condition? _____

Purpose of this appointment: _____

I authorize and give permission to Dr. Jones to place before and after photos of me on his website, www.perfectgrin.com. I also give Dr. Jones permission to use the photos for educating patients on cosmetic dentistry, displays in the office, publications and journals.

Signature: _____ Date: _____

I verify that the above information is correct to the best of my knowledge. I authorize the doctor to take x-rays and perform any other procedures or tests necessary to make a complete diagnosis of my dental needs. I also authorize the doctor to perform any forms of treatment and render any medications which may be necessary or indicated.

Signature: _____ Date: _____

CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Relationship to Patient

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date

Patient Signature

Date

Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date

Patient Signature

Date

Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date

Patient Signature

Date

Dentist Signature

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date

Patient Signature

Date

Dentist Signature

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____) _____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (____) _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone (____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Heart Valves or Joints, Screws, etc | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Venereal Disease |

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? Yes No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? Yes No

Are you taking any medication at this time? _____ If so, what? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) Yes No

Are you under the care of a physician? Yes No For what conditions? _____

If patient is a child, what is his/her weight? _____

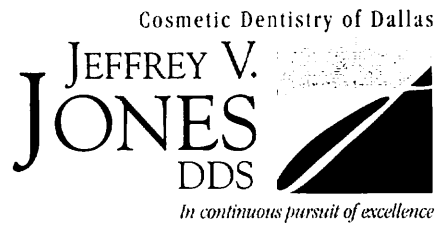
(Women) Do you suspect that you are pregnant? Yes No Due date _____

Are you nursing? Yes No Taking birth control pills? Yes No

Is there anything else we should know about your medical history? _____

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We are delighted to welcome you to our practice and are pleased that you have chosen us for your dental needs. Dr. Jones has been providing cosmetic and implant dentistry, as well as general dental care since 1985. We are serious about providing superior dental care at reasonable prices, and are proud of our dedication to our patients. Our goal is to help you feel and look your best through excellent dental care.

Our hours of operation are M-W, 7:45-5:15, and Thurs, 7:45-4:00, with occasional extended hours under special circumstances. If you are unable to keep the appointment that you have scheduled with us, please notify us at least 24 hours in advance. We will be glad to reschedule the appointment at a more convenient time if necessary. Our location is east of Downtown Dallas across the street from the Barnett and Wadley Towers of Baylor Hospital. Your parking options are using the meters on Bird Street, or our parking garage off Washington Ave. (\$3.00 flat rate).

For more information about our office or about Dr. Jones, visit our web site, www.perfectgrin.com.