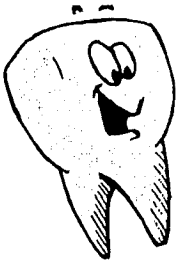
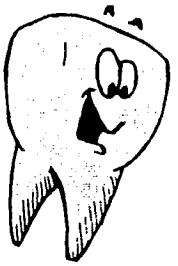


Tell Us About Your Child



Child's Name: _____ Sex: M F Age:_____
Nickname: _____ EMAIL_____
HomeAddress: _____
City: _____State:_____Zip:_____Phone:_____
Social Security#:___-____-___ Birthdate: ____/_____/_____
School: _____ _____Grade:_____
Hobbies: _____
How did you hear about us: _____
Person Responsible for Account: _____
Parent's Marital Status ☐ **Single** ☐ **Married** ☐ **Partnered** ☐ **Widowed** ☐ **Divorced**

PARENT OR GUARDIAN INFORMATION (MOTHER OR GUARDIAN)

Name: _____Relationship:_____
Address: (if different than child's)
_____
City: _____State:_____Zip:_____Cell:_____
Social Security #____-____-____ Birthdate: _____
Employer: _____Occupation:_____
Work Phone_____

PARENT OR GUARDIAN INFORMATION (FATHER OR GUARDIAN)

Name: _____Relationship:_____
Address: (if different than child's)
_____
City:_____State:_____Zip:_____Phone:_____
Social Security #_____-_____-_____ Birthdate: _____Cell: _____
Employer: _____Occupation:_____
Work Phone_____

PRIMARY DENTAL INSURANCE

Insured's Name: _____Relationship:_____
Social Security # _____-_____-_____ Birthdate: _____
Employer: _____
InsuranceCompany_____Group#_____ID#_____
Ins. Co. Address_____City:_____State:_____Zip:_____

FINANCIAL ARRANGEMENTS

Payment in full is due at each appointment. I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Signature of Parent or Guardian_____Date_____

Child's Name_____ DOB_____ Physician's Name_____
Physician's Phone Number_____

Patient Medical History

 Yes No Is your child in good health?
 Yes No has your child ever had a health problems or been hospitalized?
Date _____ Reason? _____
 Yes No Is your child taking any medicines now?
If yes, what? _____ Reason_____
 Yes No is your child allergic to medicine or food? If yes, what _____
 Yes No Were there any problems at birth? If so, what? _____
 Yes No has your child received emergency medical treatment?
When/Why? _____
 Yes No Was your child Breast fed Bottle fed until what age? _____
 Yes No Are your child's immunizations up to date?

Please check if your child presently has or previously had any of the following:

 AIDS/HIV
 Diabetes/Endocrine problems
 Hyperactivity/ADD/ADHD
 Rheumatic Fever
 Anemia
 Ear disorders/Hearing loss
 Jaundice
 Sickle Cell Anemia/Trait
 Asthma/Breathing Problems
 Epilepsy/Seizures
 Kidney/Liver disease
 Skin disease
 Bleeding tendency
 Eye disorders/Blindness
 Lung disease
 Speech problem
 Blood disease/transfusion
 Fainting/Dizziness/ Headaches
 Measles/Mumps
 Strep Throat
 Bone disorder
 Hay fever/Seasonal allergies
 Muscle disorder
 Stomach problem
 Cancer/ Tumors
 Heart Condition/Heart Murmur
 Nose/throat disorder
 Cerebral Palsy
 Hepatitis
 Nutritional disorder
 Chicken Pox
 Hormone Disorder
 Prolonged Illness
 Other _____

Patient Dental History

 Yes No has your child ever been to the dentist? Name of dentist & date_____
 Yes No Has your child experienced any unfavorable reaction from previous dental care?
Explain _____
 Yes No Does your child's jaw make noise or have pain with chewing, yawning, or wide opening?
 Yes No Does your child have any untreated injuries or inflamed areas in or around his/her mouth?
 Yes No Do your child's gums bleed?
 Yes No Has your child ever received a local anesthetic? Any complications? _____
 Yes No Has your child ever had nitrous oxide ("laughing gas")? Any complications? _____
 Yes No Does your family drink well water or city water? Does the water contain fluoride? _____ Yes _____ No
 Yes No Does your child take any vitamins or fluorides (drops or tablets)?
 Yes No Does your child use fluoride toothpaste?
When are your child's teeth brushed? By whom? _____
 Upon rising Before bed Right after eating meals or any food
 Yes No Does your child have or has he/she had any of the following:
 Cavities/Toothache Lips/Finger biting Sippy Cup Thumb/Finger/Pacifier habit
 Cheek/Tongue chewing Mouth breathing sleeping with bottle other _____
 Gum Infections Trauma
 Yes No Does your child have a dental condition about which you are especially concerned? If yes, explain _____
 Yes No is there anything else about your child that you would like for us to know in order to better his/her oral care maintenance? _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature _____ Date_____

FINANCIAL POLICY

Mt. Juliet Family & Cosmetic Dentistry
Corey Jackson, D.D.S., LLC
(615) 754-5840

Payment is due in full at the time of service. We accept cash, personal checks, Visa, Discover, MasterCard and most debit cards. There will be a $35.00 charge for any returned check.

As a courtesy, we will be glad to file your insurance claim for you. However, you will be responsible at the time of service for estimated or actual co-pays, previous balances, deductibles, treatments not covered by your insurance carrier, etc.

Dental finance plans are also available from third party financial institutions. We do not offer in-house financing. However, we encourage you to consider the advantages of outside plans, including no-interest options for qualified applicants through Care Credit.

Broken appointments are a burden, especially those without prior notification. We request a minimum 24-hour notice so that we can schedule other patients. We reserve the right to add a service fee for broken appointments.

Note that with some procedures and/or in certain circumstances, partial payment or payment in full may be required in advance. We will advise you if applicable.

Accounts with balances older than 30 days may incur additional fees.

Dental insurance is a contract between you, your employer, and the dental insurance company. We are not a part of that contract. Our relationship is with you, the patient.

Insurance companies may arbitrarily select what services they will cover. When we verify benefits, your carrier will give us the general provisions of your coverage plan along with estimated benefit amounts. Actual claims may vary, so we will not know the exact dollar amount until the claim is actually paid.

We will try to assist you in interpreting and understanding the terms of your dental insurance. However, these kinds of questions are often best answered by your insurance carrier. It is your responsibility to know your insurance benefits and limitations.

_____

RESPONSIBLE PARTY SIGNATURE

Amalgam versus Composite Fillings

Our office no longer provides amalgam fillings (silver) and I would like to explain why:

1. Over time the amalgam filling expands and will eventually crack the tooth. Many of the full coverage crowns that we do on back teeth are because of an old amalgam filling that has cracked the tooth.

2. Amalgam filling contains mercury, which is a poison. Research has not shown conclusively whether or not it is released into the body, but the possibility exists.

These two reasons were enough to make me discontinue using amalgam but another one has emerged as well. A mouth with only composite fillings looks completely natural, which is much more appealing than silver or black fillings.

Unfortunately, some dental insurance companies only pay benefits for amalgam fillings therefore leaving the patient the responsibility for paying the difference in the two restorations. That is changing gradually as employers and insurance companies realize the value of the composite fillings.

If you have any questions please ask my office manager Kim Elmore or me.

Thank You,

Corey Jackson, DDS

PLEASE SIGN:_____ **DATE:**_____

Mount Juliet Family Dentistry

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (*HIPPA*), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to :

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE: _____ **INITIALS:** _____

REASON: _____