Mt. Juliet Family and Cosmetic Dentistry
Corey Jackson, D.D.S.
40 West Caldwell Street, Suite 101 Mt. Juliet TN, 37122
(615) 754-5840

Today's Date_____ Email Address_____

Name:_____ I prefer to be called:_____ ☐ Male ☐ Female

Birthday____/____/____ Age:____ Social Security #:_____ ☐ Single ☐ Married ☐ Divorced ☐ Separated

Home Address:_____
City State Zip

Home Phone#:_____Cell/Other:_____ Work #:_____ Drivers License #:_____

Where & When are best times to reach you:_____ Whom may we thank for referring you:_____

Employer:_____ _____How long there?:_____ Occupation:_____

Employers Address:_____
City State Zip

Neighbor or Relative not living with you

His/ Her Name_____ Relation:_____Work#_____Home#_____

Address:_____
City State Zip

Spouse Information

His/ Her Name_____ Work#_____ Cell#_____

Insurance Information

Primary Insurance Dental Coverage? ☐ Yes ☐ No

Insurance Company Name:_____ _____Phone #: (____)_____ Group #_____

InsuranceCompanyAddress:_____
City State Zip

Insured's Name:_____ Insured's social Security #:_____Insured's DOB ___/___/___Relation:_____

Insured's Employer:_____ Employer's Address:_____
City/ State Zip

Payment is due in full at the time of treatment

If this office accepts insurance, I understand that I am responsible for the payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I herby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I herby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection cost, court costs, and reasonable attorney fees incurred to effect collection on this account.

TO AVOID A $35 CANCELLATION FEE—24 HOUR NOTICE IS REQUIRED

_____
Signature **Date**

Dental History

Why have you come to the dentist today? _____

Are your teeth sensitive to heat, cold or anything else? _____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily: ☐ Yes ☐ No

Types of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Previous Dentist? _____ Last visit date? _____

Would you like fresher breath? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's name: _____

Address: _____
Street

_____
City State Zip

Phone #: (___) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin ☐ Yes ☐ No

For women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: _____ Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell
Y N Anemia	Y N Diabetes	Y N Heart attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/ AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription / Over the Counter drugs? ☐ Yes ☐ No If yes, please list each one: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry/Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reaction: _____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this office's Notice of Privacy Policy.

_____ _____
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: _____