

Jenkins Dental Care



We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called _____ [] Male [] Female
[] Single [] Married [] Child [] Other Birth date: ___/___/___ Age: _____ S.S. #: _____
Home Address: _____ City _____ State _____ Zip _____
Home Phone: (____) _____ Work: (____) _____ ext. ____ Pager: (____) _____
Cell: (____) _____ E-mail Address: _____
Employer: _____ How long there? _____ Occupation: _____
Employer's Address: _____ City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR ACCOUNT

[] Same as above Name: _____ Birth date: ___/___/___ Relation: _____
Billing Address: _____ City _____ State _____ Zip _____
Home Phone: (____) _____ Work: (____) _____ S.S. #: _____
Employer: _____ How long there? _____ Occupation: _____

SPOUSE INFORMATION

[] Same as above Name: _____ Birth date: ___/___/___
Employer: _____ Work Phone: (____) _____ ext. ____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____
Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____
Insured's Social Security #: _____ Insured's Employer: _____

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MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (____) _____

Pharmacy Preference: _____

MEDICAL ALERTS: Please inform the office if health conditions or medications change. *This condition may require antibiotic pre-medication for certain dental procedures. Please check those that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> HIV*/AIDS | <input type="checkbox"/> Stent* __/__/__ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints* _____ | <input type="checkbox"/> Fever Blisters/Cold Sores | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Surgical Shunt* |
| <input type="checkbox"/> Artificial Heart Valves* | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Problems* | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Infection | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Rheumatic Fever | |

YES NO (Please mark below)

Do you have any health problems that were not listed above or need further clarifications?

If yes, explain: _____

Are you now under the care of a physician? If yes, explain:

Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, explain: _____

Are you taking any **medications** including blood thinners or bone-strengthening medications? If yes, list:

Are you **allergic** to any medications or substances?

If yes, please check box below:

Aspirin Penicillin Codeine Iodine Metal Latex Other _____

Do you use tobacco? If yes, explain: _____

WOMEN (Please check): Pregnant (due date _____) Nursing Trying to get pregnant Not pregnant
 Taking oral contraceptives

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DENTAL HEALTH HISTORY

PREVIOUS DENTIST: _____

LAST VISIT DATE WITH ABOVE DENTIST: _____

LAST CLEANING DATE: _____

Please help us better understand your dental health needs and goals by answering the following questions.

(check the best answer):

1. Have you had a dental cleaning in the past 6 months? Yes No
2. I have a low moderate high fear of going to the dentist.
3. My mouth and teeth are very moderately not comfortable.
4. I am very satisfied satisfied dissatisfied with the appearance of my teeth.
5. I think my present state of dental health is excellent good fair poor.
6. My gums bleed every time I brush my teeth on occasion never.
7. My main concerns with my dental health are: _____

Please check which statement below best represents the level of dental health you wish to achieve.

HEALTH LEVEL I - Emergency Care

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment.

I am not very interested in thinking about the future of my teeth at this time.

HEALTH LEVEL II - Maintenance Care

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

HEALTH LEVEL III - Comprehensive Care

I am interested in comprehensive care to achieve and maintain a higher level of dental health.

I am concerned about treating the causes of dental diseases, not simply the effects.

I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

HEALTH LEVEL IV - Comprehensive & Cosmetic Care

I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health.

I am concerned about treating the causes of dental diseases, not simply the effects.

I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.

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CONSENT, ASSIGNMENT AND RELEASE

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least 2 working days advanced notification so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. Otherwise, a missed appointment fee of \$25.00 may be charged to your account. We value your time, please value ours.

I, _____, have had full opportunity to consider the contents of this consent form. 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 only necessary treatment, payment activities, and health care operations.

Being the parent or guardian of _____, I do hereby request and authorize Jenkins Dental care to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered.

Children under the age of 18 should be accompanied by an adult to all appointments unless previously authorized by Jenkins Dental Care.

Adult Patient / Guardian Signature

I, the undersigned, have insurance with _____ insurance company and assign directly to Jenkins Dental Care all benefits, in any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. As a courtesy, we estimate your portion for payment under insured claims; however, **I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY MY INSURANCE.**

I give my permission to all patient members covered under my insurance, to use my benefits allowed through my insurance plan. I understand that by signing this, any charges incurred by the members listed below not covered by my insurance will be my responsibility. I authorize the use of this signature on all of my insurance submissions whether manual or electronic.

Adult Patient / Guardian Signature

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. **A \$25.00 collection fee will be assessed to all unpaid balances 75 days and over. A \$30.00 fee will be added to all returned checks.** I accept all finance charges up to 18% and all billing charges added to my account accruing after 60 days.

HIPAA: NOTICE OF PRIVACY PRACTICES**JENKINS DENTAL CARE**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

-We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

-We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

-You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.____ for each page, \$____ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: W. Bradford Jenkins
Telephone: 662-887-3426 Fax: 662-887-3698
E-mail: hipaa@jenkinsdentalcare.com
Address: 211 Hwy 82E, Indianola, MS 38751

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I, _____, have read and or received a copy of this office's Notice of Privacy Practices.

Adult Patient / Guardian Signature

Date