



Thank You for Selecting Our Dental Team

To help us meet your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (confidential)

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check appropriate box: Minor Single Married Separated Divorced Widowed

If Student, Name of School / College _____ City _____ State _____ Full Time Part Time

Patient or Parent / Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent / Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? Yes No

For your convenience, we offer the following methods of payment: Please check the option you prefer. **Payment in full at each appointment.**

- Cash Personal Check Credit Card Visa Mastercard Discover American Express Care Credit

Insurance Information - Please provide insurance card

Name of insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Do you have any additional insurance? Yes No If yes, complete the following and provide insurance card.

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you allergic to or have you had any reactions to the following? | | |
| 3. Are you taking any medication(s) including non-prescription medicine? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. Novocan) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> | Barbituates | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you use controlled substance? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 12. Women Only | | |
| | | | Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have or have you had any of the following?

- | | Yes | No | | Yes | No | | Yes | No |
|-----------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids or foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaws? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read, understood, and accurately answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental

insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (parent/guardian if minor)

Jeffus Family Dental

DR. JUSTIN JEFFUS

OUR FINANCIAL POLICY

Non-insured patients are expected to pay in full with cash, check or credit card the day the services are rendered unless specific arrangements are made in writing, in advance.

For those patients who are covered by insurance, I authorize my insurance company to pay all insurance benefits otherwise payable to me to Jeffus Family Dental, for services rendered and hereby assign those benefits to Jeffus Family Dental. This means that you sign the portion of your insurance form that "assigns" payments to our office. Most dental insurances **DO NOT COVER 100%** of the cost of your treatment. Because of this and extreme delay in receiving payment by your insurance company, you will be asked to pay your deductible and your estimated portion of the charges the day the services are rendered.

We will estimate as closely as possible your coverage, but until we receive payment from the insurance company, it is just an estimate. We will assist you in dealing with your insurance company, but the ultimate responsibility for payment by your insurance company lies with you. After 45 days, any remaining balance not covered by or received from your insurance company will be due in full from you.

Until my accounts are finally settled, I give direct consent to receive communications regarding my accounts from all services and any collectors of my accounts, through various means such as: any call, landline, or text number that I provide, any email address that I provide, auto dialer system, voicemail messages, and other forms of communication.

Payments are due and payable at Jeffus Family Dental's place of business at 67 S. Main St, Pontotoc, Ms 38863. If this account is referred for collection, debtor agrees to pay Jeffus Family Dental an additional 1/3% of the original bill (including interest) of \$150.00 (minimum) as attorney fees, plus all pre-judgment cost of collections to include court costs. Debtors consents to the jurisdiction of Pontotoc County, Mississippi court system for enforcement of payment of this account. Debtor agrees to pay interest on all overdue amounts at the rate of 1.5% a month (15% annual percentage rate) or such other lesser amounts as is allowed by the laws of the state of Mississippi, part of the consideration of extending credit to me, I hereby agree to pay the above account and be personally liable of all charges on the account made by any of my family members or person residing in my household.

Feel free to ask any questions that remain unanswered either before or after treatment. We wish to help you all we can.

I have read the above and agree to its terms _____

{Patient's Signature}

Date _____

Witness Harry B. _____

Please Sign After Reading:

Charges for dental services are due and payable at the time of the service. Payment may be made with cash, check, Visa, MasterCard or Debit cards. **After 60 days, all balances will accrue a 1.5% financial charge.** I understand that I (or the guarantor listed) am ultimately responsible for any delinquent charges on this account (including those in association with the Practice, collections agencies and/or attorney's fees.)

Patients with Insurance: As a courtesy to our patients, this office will process your dental insurance claims for your convenience. I understand that the "Estimated Patient's Portion" that may be quoted to me is **only an estimate.** I authorize payment of the dental benefits payable to the doctor(s). I understand that I am fully responsible for all charges made at this office excluding any insurance payments and am aware that if my insurance has not paid the doctor(s) within **six (6) weeks** from the date of service, **I am responsible for paying the balance immediately.**

Consent: It is necessary for us to have the consent of our patients or a d parent/ legal guardian of minors prior to rendering dental services.

My signature below therefore authorizes the doctor to perform any and all forms of dental treatment, medication, and/or therapy that may be indicated. I understand the dental treatment or course of dental treatment has a risk of death, brain damage, quadriplegia, paraplegia, the loss of function or loss of an organ or limb, or disfiguring scars, and that I may ask questions concerning such dental treatment or course of dental treatment.

It is also necessary for us to have the consent of our patients or parent/legal guardian or minors to email dental x-rays and/or dental photographs to other dental professionals such as specialists or laboratory technicians via a non-encrypted web source. My signature below therefore gives the doctor and/ or qualified staff of Jeffus Family Dental permission to email other dental professionals my dental x-rays or pictures as needed for my individual treatment.

HIPPA Policy: As health care providers, we are legally required to protect the privacy of your health information and to provide you with notice about our legal duties and privacy practices.

Please read the HIPPA Policy Form before signing below.

I have read the HIPPA Policies and understand the information provided.

Patient Signature (Parent signature if patient is under 18 years of age).

Date: _____



Our practice is obligated to protect the privacy of your health/dental information. Therefore, we will not release information regarding your appointments, account information, insurance, etc. during telephone conversations, etc., to anyone, unless you authorize us to do so by printing the names of those people below. I hereby authorize Jeffus Family Dental to release the information to myself and the following person or persons (ie: mother, father, spouse, etc.) and accept Jeffus Family Dental does not have the ability to verify the identity of individuals who call requesting information.

_____ / _____

Name

Relationship

_____ / _____

Name

Relationship

_____ / _____

Name

Relationship

Signature of Patient or Guardian (must be 18 or older)

_____ Date: _____