

# 🦷 Welcome 🦷

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## 🦷 Patient Information

Date \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_ Email \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

## 🦷 Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

## 🦷 Additional Insurance

Is patient covered by additional insurance?  Yes  No  
Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

Please Complete Both Sides

## Dental History

Reason for Today's Visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Check ( ✓ ) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check ( ✓ ) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | Describe _____                                | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |

### MEDICATIONS

List medications you are currently taking:

### ALLERGIES

## Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**

# **JXR Dental Offices**

## **Financial Policy**

Welcome to the practice of Dr. Jordi X. Rodriguez. To assist you in planning for your health care cost, we want to inform you of our financial policy. We welcome any questions you may have regarding our services and policies.

**Payment is expected when services are rendered, including estimated insurance copayments.** For your convenience we accept Visa, Mastercard, Discover, Cash and Care Credit. **We do not accept checks.** Failure to pay your account will make you responsible for any collection fees including court costs and reasonable attorney's fees incurred in the process.

Payment arrangements are made only for procedures that require more than one visit. These payment arrangements are done according to the number of visits any give treatment will take. Payments are expected at each treatment visit and the full balance should be covered at the last visit.

## **Failed Appointment Policy**

Please be aware that our office is a fee - for – service practice. Our goal is to provide you and your family with quality dental care. This is achieved by giving each patient undivided personal attention and time. Thus an appointment given at our office is exclusively for you.

We kindly request that if you cannot keep an appointment to please call to cancel with more than 24hrs. That way we have sufficient time to give that time slot to another patient.

Please note that two failed appointments or cancellations without 24 hr notice will result in a broken appointment charge. We appreciate your cooperation with this matter.

**I have read all the previously stated information and agree to it.**

Signature:

**Patient or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

## **JXR Dental Offices Dental Insurance Policy**

We are happy to accept your insurance at the time of visit, and we will file your insurance forms at no charge. This is a courtesy we extend to our patients. All insurance claims are ultimately your responsibility.

Because your insurance is a contract between you and your carrier, and does not guarantee payment to our office, we cannot become involved in disputes regarding claims, deductibles, co-payments, non-covered charges, or other denial of payment. It is part of our contractual agreement with any PPO or Indemnity Dental Carrier to collect any patient responsibility.

Please be aware the insurance companies only pay for two cleanings a year. Some companies do not cover bondings (natural looking fillings) in posterior teeth because those are more expensive than amalgams (silver fillings). They will pay bondings as amalgams because those companies consider it as a cosmetic issue. The patient will be responsible for the difference in cost.

Most insurance companies do not cover 100% of all dental expenses. Your portion, not covered by dental insurance, is due at the time services are rendered.

Please be aware we are only capable of approximating your copayment portion due to the large numbers of insurance companies and the periodic changes within their contracts. Many changes are done without notifying the dental offices. Should you have any questions regarding your coverage please call your insurance carrier.

**I have read all the previously stated information and agree to it.**

Signature:

**Patient or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_