Welcome to Madeira Dentistry

PATIENT REGISTRATION

Name: _____ Date of Birth: _____

Address: _____ City: _____ State:_____ Zip Code: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Marital Status: _____
Occupation: _____Employer:_____

Parent's Name (if patient is a minor): _____

Name and Phone Number of Emergency Contact: _____

Whom may we thank for referring you to our office? _____

Email: _____

FINANCIAL INFORMATION

Name of person financially responsible for this patient: _____

Address: _____City: _____State: _____ Zip Code: _____
Home Phone: _____ Date of Birth: _____ Social Security #:_____
Employer Name and Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____Group or Contract No:_____
Address: _____Phone Number:_____
Insured's Name:_____ Insured's Date of Birth: _____
Insured's Social Security No:_____ Insured's Employer:_____
Secondary Insurance Carrier:_____ Group or Contact No:_____
Address: _____ Phone Number: _____
Insured's Name;_____ Insured's Date of Birth: _____
Subscribers Social Security No: _____ Insured's Employer: _____

Please note that our office policy requires payment at the time services are provided. Regardless of any anticipated insurance benefits, I understand that I am fully responsible for the payment of any balance on this account:

Signature: _____ Date: _____

HEALTH HISTORY

Patient Name: _____ How do you wish to be addressed: _____
General Information (For our records only and will be kept confidential):
Physician name: _____ Date of last physical exam: _____
Name of previous dentist: _____ Date of last dental exam: _____
Did you have dental x-rays? (if known):_____
CIRCLE:

YES NO 1. Are you having pain or discomfort at this time? _____
YES NO 2. Do you feel nervous about having dental treatment? _____
YES NO 3. Have you ever had a bad experience in a dental office? _____
YES NO 4. Have you been a patient in the hospital during the last two years? _____
YES NO 5. Have you been under the care of a medical doctor during the last two years? _____
YES NO 6. Have you taken any medicines or drugs in the last two years? If yes, which ones?
_____
YES NO 7. Are you taking any vitamins, herbal supplements, or "cures"? _____
YES NO 8. Are you allergic to (i.e. hives, rash, itching, difficulty breathing) any medicines? If so, which ones? _____
_____
YES NO 9. Are you intolerant to any medicines (upset stomach, ringing in ears, nausea, vomiting?) If so, which ones? _____
YES NO 10. WOMEN: Are you pregnant? _____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH APPLY TO YOUR PRESENT OR PAST HEALTH

Heart Failure	Any Type of Implant	Congenital Heart	Sexually Transmitted
Ulcers	** (heart valve, knee,	Lesions	Disease
Alcoholism	joint, etc)	Hay Fever	Heart Surgery
Herpes	Heart Murmur**	Sickle Cell Disease	Blood Transfusion
Heart Disease/Failure	Tuberculosis (TB)	Use of Tobacco	Drug Addiction
Mental Retardation	Birth Defects	Sinus Trouble	Cancer (type)
Cortisone Medicine	Rheumatic Fever	Bruise Easily	_____
Seizures/Epilepsy	Asthma	Thyroid Disease	Radiation Therapy
Angina Pectoris	HIV Positive/ARC	Allergies or Hives	Hemophilia
Emphysema	AIDS	Liver Disease	Anemia
Glaucoma	Psychiatric Treatment	Heart Pacemaker/ICD	Chemotherapy
Fainting or Dizzy	Arthritis	Diabetes	Kidney Trouble
High Blood Pressure	Cold Sores	Jaundice	Any Type of
Cough (>10 days)	Hepatitis A, B or C	Artificial Hip/Knee	Transplant**
Pain in Jaw Joints			

Any other conditions not listed: _____
**For these conditions only, is antibiotic pre-medication required prior to your dental appointment? _____

CIRCLE

YES NO 11. Have you ever had oral hygiene instructions (brushing/flossing your teeth)?
YES NO 12. Are there any growths or sores in or around your mouth?
YES NO 13. Do you have any trouble chewing?
YES NO 14. Does food catch between your teeth?
YES NO 15. Do you have pain in or near your ears?
YES NO 16. Do you habitually clench or grind your teeth during the day or night?
YES NO 17. Have you ever been told that you have "gum problems"?
YES NO 18. Do you now have bleeding gums or any other gum condition?
YES NO 19. Is there anything you dislike about your smile? _____

Signature :_____ Date: _____

Madeira Dentistry
Keith D. Jackson, D.D.S.
Laura Kinlaw Jackson D.D.S.
EXCELLENCE IN RESTORATIVE
AND ESTHETIC DENTISTRY
7113 Miami Ave. Madeira, OH 45243
PHONE (513) 561-5318
www.madeiradentistry.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
Please Print Name

_____
Signature

_____
Date

Please list the name(s) of the person(s) we can share your information with:

_____

For Office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)

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Laura Kinlaw Jackson D.D.S.
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Financial Agreement

Dear Valued Patient,

Thank you for choosing our office for your dental health needs. Dr.'s William and Keith Jackson strive to provide quality dentistry at fair prices. Our payment policies are as follows: **Insured patients:** Co-pay is due at the time of service. We will call to verify benefits and get an estimate of the insurance payment for the procedures that are to be performed. The patient is responsible for paying his or her percentage of the fee at the time of service. We are only able to obtain an *estimate* of the insurance payment. If there is a balance after the insurance claim is processed the patient will be billed. We are happy to submit your insurance to your carrier, however, PPO dentists are not required to only accept PPO discounted rates for non covered services, which would mean the patient is responsible for the balance remaining. If the submitted charge exceeds the maximum covered expense, or if the patient reaches their maximum each year, the balance remaining is that of the patients.

Private pay patients: Payment is due at time of service for basic services (cleanings, exams, x-rays and fillings). We have a payment option called CARE CREDIT OR LENDING LEASE which allows a patient to make monthly payments. Please ask the office manager for details on this money saving payment option. Other options include: patient may receive a 5% discount on treatment plans estimated over $1000.00, if the fees are paid in full at time of service by cash or check. If you are paying with credit card, treatment over $1000.00 a 3% discount will be applied if paid in full.

If you have any questions regarding these policies please ask the office manager.
I have received, read, and agree to the financial agreement for Madeira Dentistry.

Acknowledgement of Appointment Cancellation Policy

In order to provide optimum scheduling to all our patients, we require a 24 hour notice of appointment cancellation. Patients who do not call within the 24 hour time will be charged a $75.00 fee. This fee is applied to all patients that are no-call no-show and same day cancellations.

I, _____ have read the above policy and understand that it is my responsibility to call 24 hours in advance in the event that I am unable to keep my scheduled appointment. I understand that failure to call in the 24 hours will result in a $75.00 fee.

Signature_____Date_____