PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By:

Day/Time Preference:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Tyler W. Jury DMD, PLLC

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No
Hepatitis A, B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Herpes ◯ Yes ◯ No
Rheumatic Fever ◯ Yes ◯ No	Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Shingles ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No
Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No
Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No
Spina Bifida ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No	Cancer ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No	Sensory Issues ◯ Yes ◯ No	TMJ/Jaw Pain ◯ Yes ◯ No
Sleep Apnea ◯ Yes ◯ No	Autoimmune Disease ◯ Yes ◯ No	Acid Reflux ◯ Yes ◯ No	

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Would you change anything about your smile?	◯ Yes ◯ No	If yes
Has anyone ever told you that you stop breathing while you sleep?	◯ Yes ◯ No	
Are you aware or has anyone ever told you that you grind or clench your teeth?	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Consent for Treatment and Promise of Payment

I hereby consent to the performance of a course of dental procedures, deemed necessary and desirable for any condition found on examination, or any dental treatment or procedures which may later become apparent during treatment. This consent shall extend to all treatments, services, medications and operations upon the teeth and jaws as may be necessary to correct oral deficiency, abnormality and/or infection. I consent to the administration of anesthetic agents for my dental treatment. I acknowledge that no guarantee or assurance is made as to the results that may be obtained.

I understand that services and cost may change once treatment commences. I acknowledge that I am fully responsible for all fees incurred, and any applicable insurance is not a promise of payment. I understand that I am responsible for any problems, delays, or denials for payment with my insurance company. If my account becomes delinquent it will go to a collections lawyer, and I am fully responsible for all filing, collections, and delinquent account charges.

Signature _____ Date _____

Relationship to patient (if parent or guardian) _____

Consent for Use and Disclosure of Health Information Health Insurance Portability Accountability Act (HIPAA)

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A staff member can provide you with a copy of this Consent, we encourage you to read.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Dr. Tyler Jury.

Patient Giving Consent

I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date _____

Relationship to patient (if parent or guardian) _____

Patient Revoking Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature _____ Date _____

Relationship to patient (if parent or guardian) _____

Notice of Privacy Practices

I acknowledge that I have been notified that our NOTICE OF PRACTICE POLICIES can be obtained via our office. This document is printable via the website for your website for your records. HIPAA website: http://www.hhs.gov/ocr/hipaa/finalreg.html (You may refuse to sign this acknowledgement)

Signature _____ Date _____

Relationship to patient (if parent or guardian) _____

Written Financial Policy

Thank you for choosing Jury Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.
Payment Options:

-Visa, MasterCard, American Express, Discover Card or Cash, Check

-NO INTEREST**

Please note:

Dr. Jury requires full payment on the day your service is provided. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment. If you choose to discontinue care before treatment is complete, any available refund will be determined upon review of your case.
For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. **However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.**
If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print

* 1 If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
* 2 Subject to credit approval

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. Your information will only be shared when referred to specialist offices and when necessary to file insurance claims.

You may refuse to sign this acknowledgement

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

_____ _____

{Signature of Patient and/or Guardian} {Date}

{Relationship to Patient} Self or Other: _____

I, _____, acknowledge and allow Jury Family Dentistry- Tyler W. Jury DMD to share my information with the following people besides those already stated within the Notice of Privacy Practices

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child (ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call [ ] my home phone [ ] my work number [ ] my cell number

_____ _____ _____

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call OR

[ ] you may e-mail me at _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

Jury Family Dentistry

Consent to Share Confidential Medical/Dental Information

Patient Name: _____

Birth Date: _____

I hereby Authorize Jury Family Dentistry to Share:

My appointment times, dates, and reasons for the visits.

With the Following People:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____

Date: _____

Consent for Photo/Image use

I, the undersigned, hereby authorize the office of Dr. Tyler Jury to utilize clinical photos for the purpose of case tracking, communication with dental laboratories, documenting cases for future reference (educational, teaching), marketing and/or advertising purpose.

(Check all that apply)

_____ Before and after pictures of my teeth
_____ Before and after pictures of my full face
_____ Before and after pictures of the teeth and/or full face of my minor child
_____ Refusal of photos/images

By signing this authorization I waive any claims of breach of privacy pertaining to the release of any photographic or digital images as checked above. I acknowledge that I have received a copy of the privacy policies of this office.

_____ _____
Signature of Patient or Parent Date

_____ _____
Witness Signature Date
(Staff member)