LEGAL NAME: ________________________________ ____________ Please Check: MARRIED ▒ SINGLE ▒ DIVORCED ▒ WIDOWED ▒ :: MALE ▒ FEMALE ▒

LAST FIRST M Nickname

MAILING ADDRESS: ____

CITY STATE ZIP COUNTY

STREET ADDRESS (if different from Mailing) ____

CITY STATE ZIP COUNTY

Social Security Number: ________________________________ BIRTHDATE: ______________________________

TELEPHONE: HOME:_________________________WORK__________________ext:_________CELL or PAGER___________________________

PLACE OF EMPLOYMENT (OR SCHOOL) ____________________________ Email: ____

- **Due to privacy laws, you must give name and relationship of any persons, <u>including spouse</u>, that you give permission for us to discuss, on your behalf, insurance information, account charges or payments, treatment, or appointments:** ***If we are filing on someone else's insurance, you must list them here. Please specify individual(s) and any restrictions.***
  ____
  ____
- **PROVIDE A PERSON TO CONTACT IN CASE OF EMERGENCY: ALSO YOU ARE PROVIDING PERMISSION TO SPEAK WITH THIS INDIVIDUAL(s) REGARDING SPECIFICS OF EMERGENCY (*<u>LIST AN INDIVIDUAL LIVING OUTSIDE OF YOUR RESIDENCE</u>*):**
- NAME: _______________PHONE: (Home) ______________ (Work) _______________ (Cell)________________
  RELATIONSHIP: ____________________ADDITIONAL INFO OR INDIVIDUAL(s) if desired: ____________________
  ____

Is there anyone we may thank for referring you to our office? ____

<u>HUSBAND OR *FATHER'S - Info for minor patients*</u>	**<u>WIFE OR *MOTHER'S Info for minor patients*</u>**
NAME	NAME
ADDRESS CITY	ADDRESS CITY
HOME TELEPHONE CELL or PAGER	HOME TELEPHONE CELL or PAGER
SS# BIRTHDATE	SS# BIRTHDATE
EMPLOYER	EMPLOYER
Employer Telephone	EMPLOYER TELEPHONE
(for minors) Marital Status to listed Mother_______________	(for minors) Marital Status to listed Father____________________

INSURANCE AUTHORIZATION- <u>Skip this box if you do not have dental insurance</u>

Dental Company Name:____________________________Telephone#______________________Group/Policy#_____________________________

Policyholder's Name (as appears on policy): ________________________________ Policyholder's Employer ________________________________

Policyholder's Social Security AND Employee # (if Applicable)____Policyholder's Birth date____________

I hereby authorize this office to act as an agent in obtaining third party payment. Such payment, where applicable by law, will be paid directly to the dental office against my account. I understand that I am responsible for all costs of dental treatment regardless of insurance reimbursement or consideration.. I understand I will be responsible for all legal and/or collection costs incurred to effect the collection of my account. This authorization is valid until I notify the office otherwise.

____

SIGNATURE REQUIRED, **IF INSURED** DATE

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand I have the right to refuse any recommended treatment. I grant the release of my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I understand that release of information will be only to those authorities I have consented release to. I agree for images of my smile and/or existing pathology /corrections to be used for patient education and/or promotional purposes. I understand my identity will not be released. I understand that non-emergency cancellations or failure to appear for scheduled appointments are subject to a failed appointment fee at the discretion of the office and that I may be required to prepay for treatment if I repeatedly fail to keep my appointments. I understand there will be service fees (18% annually) applied to any unpaid balances after 59 days. I understand all account balances must be paid within 90 days. In case of default of account, I understand I will be responsible individually and/or as an officer of a corporation for all legal and/or collection costs incurred to effect the collection of my account. I understand and agree that the office can obtain my credit report to aid in collection recovery and/or account management. The information on this page is correct to the best of my knowledge. This authorization is valid until I notify the office, by written statement.

____

SIGNATURE OF RESPONSIBLE PARTY (REQUIRED FOR ALL TREATMENT) DATE

Note: Responsible party must be over the age of 18 or may be required to provide Declaration of emancipation or marriage certificate. If the responsible party is other than the patient, and the patient is over the age of 18, the patient must also cosign this form.

Office Use : ID ____

PATIENT NAME____**DATE**________________________________

DENTAL HISTORY — Please Circle

Question		
Describe any specific dental problems? ________________	YES	NO
Would you like to change your smile? ________________	YES	NO
Do you brush and floss on a regular basis? ________________	YES	NO
Does floss shred or does food pack or catch between your teeth? ________________	YES	NO
Has your past dental experiences always been positive? ________________	YES	NO
Do you smoke or chew tobacco? ________________	YES	NO
Do you want to quit using tobacco products? ________________	YES	NO
Do you have an ongoing problem with breath malodor? ________________	YES	NO

Name of previous dentist (optional) ________________________________

MEDICAL HISTORY

Please list the names and phone numbers of all physicians who are currently providing you care.

____

____

What prescription or over the counter medications, pills or drugs are you taking or using?

____

____

____

What was the date of your last medical evaluation?________________________________

If you are you under a physician's care now, why? ________________________________

List hospitalizations and/or major operation(s) or injury? ________________________________

If you have taken appetite suppressants in the last 3 mo., list what medication & how long? ________________

Are you on a special diet? ________________________________ **YES NO**

Is your mouth dry? ________________________________ **YES NO**

Are you allergic to any medications or substances? (Please check) ___ **Aspirin** ___**Penicillin** ___ **Codeine** ___ **Acrylic** ___ **Metal** ___ **Latex Rubber** ___ **Other** ________________________________ **YES NO**

FOR WOMEN ONLY: Is there any possibility you are pregnant? ____ **Are you nursing?** ___**Are you taking oral contraceptive?** ___

*****Please circle any medical conditions you've had, present or past***

If yes to any of the starred (*) conditions, please notify our office immediately, before seeing the doctor …Pre-medication may be required

*Artificial Heart Valve	Leukemia	Ulcerative Colitis	Hepatitis A (Infectious)
*Heart Surgery	Tumors	Acid Reflux or GERD	Hepatitis B (Serum)
*Heart Pace Maker	Prostrate Cancer	Liver Disease	Hepatitis C
*Heart Defibrillator	Radiation Treatments	Sickle Cell Disease	Blood Disease
*Prior Bacterial Endocarditis	Chemotherapy	Yellow Jaundice	Sinus Trouble
*Organ Transplantation	Blood Transfusion	Epilepsy or Seizures	Pain in Jaw Joints
*Artificial Joint Replacement	Emphysema	Convulsions	Cortisone Medication/Shots
* Blood Thinner Medication	Anemia	Fainting/Dizziness	Sore/Enlarged Lymph Nodes
Heart Murmur	Tuberculosis	Unintentional Weight	Previous Biopsies
Mitral Valve Prolapse	Frequent Cough	Loss/Gain	Migraine Headaches
Heart Attack/Failure	Kidney Disease	Arthritis or Gout	Psychiatric Care/Psychosis
Heart Trouble/Disease	Renal Dialysis	Rheumatism	Alzheimer Dementia
Irregular Heart Beat	Thyroid Disease	Lung Disease	Nervousness
Congenital Heart Disorder	Parathyroid Disease	Shortness of Breath	Glaucoma
Heart Stent	Parkinson Disease	Asthma	Cold Sores
Angina/Chest Pain	Hemophilia (Bleeding	Hay Fever	Fever Blisters
Stroke	Problem)	Hives	Genital Herpes
Scarlet Fever	Bruise Easily	Breathing Problem	Oral Herpes
Rheumatic Fever	Stomach/Intestinal Disease	Swelling of Limbs	Venereal Disease
High Blood Pressure	Ulcers	Diabetes-HemoglobinA1c____	HIV, AIDS, or ARC
Low Blood Pressure	Frequent Diarrhea	Hypoglycemia	Shingles
Cancer	IBD or Crohn's Disease	Excessive Thirst	Sleep Disorders

Have you ever had any other serious illness not indicated above.________________________________

____

I have no medical problems, PLEASE INITIAL__________________ **Do you have a "Do Not Resuscitate Order?" If yes, PLEASE INITIAL** ____________________

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I agree to inform the dentist and staff at the next appointment.

Patient Signature (Parent or Guardian, If Minor) **DATE**

History reviewed and Significant Findings: BP: ________________________ **PULSE:**______________________ **SaO2**______________________________

____

____

Reviewed by Doctor____**DATE**______________________________

INITIAL DENTAL AND MEDICAL HISTORY

HUGH F. JORDAN, D.D.S., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

SECTION A: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS

Purpose of Consent: 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.

Acknowledgement of receipt: By signing this form, you acknowledge that you have been offered a copy of the Notice of Privacy Practice.

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 on of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other repentant matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 anytime by contacting:

Contact Person: Hugh F. Jordan, D.D.S., P.C.
Telephone: 912-537-7211 Fax: 912-537-1011
E-mail: jordandental@att.net
Address: 401 Durden Street Vidalia, GA 30474

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation so submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION B: PATIENT GIVING CONSENT (If for Minor, Use Minor's Information)

Patient's Name: ____

Patient's Address: ____

Patient's Telephone: ____

Patient's Social Security # ____

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing the Consent form, 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. I acknowledge that I have been given a copy of the office privacy practice.

Adult Patient 's Signature: ____Date:____________________

If a parent, guardian, or custodian, or personal representative signs this Consent on behalf of the patient , complete the following:

Personal Representative's Name (Please Print)____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. REQUEST, IF DESIRED.

Patient Communications (HIPAA Consent)

By law, without your authorization, Jordan Dental cannot communicate with:

1. Your spouse
2. Your adult Children or Caregivers
3. Your parents (if you are age 18 or over)

Jordan Dental may need to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or preformed
4. Account or Financial information

Please indicate below the names of people whom we may communicate with regarding your appointment, medical/dental or account information:

□ My spouse ______________________________

□ My adult children ______________________________

□ My parents ______________________________

□ My caregiver ______________________________

□ Other ______________________________

□ ***I do not wish to allow any of my information to be shared with anyone including, my spouse, or any other family member and or guardian.***

Patient name printed: ______________________________

Patient/ Parent/ Legal Guardian Signature: ______________________________

Date: ______________________________