Welcome to Dr. Jackson's Fillable Form Page

Dr. Brett Jackson
dental care

We are pleased to welcome you to our practice. If you have questions we'll be glad to help you. Please save this blank form to your computer. Re-open it on your computer, fill in these fillable pages, save the file and email it back to Dr. Brett Jackson at: drj@toothlovers.com Note: *Emailing these forms to Dr. Jackson constitutes your signature on them.*

Patient Information:

Date _____ Home Phone (_____)_____Cell Phone (_____)_____ Email _____

Name_____ _____ _____ SS/Patient ID#_____
Last Name First Name Initial

Address _____

City _____ State _____Zip_____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Divorced

Patient Employer/School _____ Occupation _____

Employer/School Address_____Employer/School 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 Middle Initial

Relation to Patient _____ Birthdate_____ ID#/SS#_____

Address _____ 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 Pt _____ Birthdate_____

Address_____ Phone (____)_____

City _____ State _____Zip_____

Subscriber Employed by_____ Business Phone (____) _____

Insurance Company _____ SS# _____

Contract #_____ Group # _____ Subscriber# _____

Names of other dependents covered under this plan_____

Dental History

Dr. Brett Jackson
dental care

Reason for today's visit_____ Date of last dental visit_____

Former Dentist_____ Date of last dental x-rays_____

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

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken filling
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

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 taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Due Date_____ Nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Check if you have had or have had any of the following.

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease/Bleeding Gums
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Prosthetic Implants (hip, knee, Etc.)
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Venereal Disease

Medications you are currently taking:

_____
_____

Allergies: (Medications, etc.)

_____
_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly

Name of Insurance Company(ies)

to Dr. Brett Jackson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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

FINANCIAL AGREEMENT
(Dr. Brett R. Jackson, DMD)

As a condition of your treatment by our office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

In the event my account becomes delinquent and is turned over to a collection agency, I agree to pay the remaining balance plus the sum of the collection fees not to exceed 40% more than the outstanding balance, in addition to reasonable attorney fees and court costs where such legal services are necessary.

_____ _____

Signature of Patient, parent or guardian Date

_____

Relationship to Patient

BRETT R. JACKSON DMD

ACKNOWLEDGMENT OF OFFICE PRIVACY POLICIES

(This policy is located on Dr. Jackson's website - Patient Forms page - under "Patient HIPPA information").

I have been notified about this office's Privacy Policies to conform with HIPAA requirements.

_____

Name (Please Print Legibly)

_____ _____

Signature Date

If you have any questions or would like a copy of the policies that you have just read, please inquire at the front desk.

CONSENT TO PROCEED

I authorize Dr. Brett R. Jackson and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which |have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction of side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a p predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____

Patient Name (Print)

Signature:_____

(Patient, legal guardian or authorized agent of patient)

Witness:_____