JUPITER DENTAL CARE

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient giving consent

Name: _____SS # _____Telephone: _____

Address: _____E-mail: _____

SECTION B: **To the Patient-PLEASE READ THE FOLLOWING CAREFULLY**

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 operation.

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 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 the Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain and changes made. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy practice, including any revisions of our notice at any time by contacting us at the above address or phone number.

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

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 this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out our treatment, payment activities and healthcare operations.

Signature: _____**Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____**Relationship to patient:** _____

If you request a copy of this office's Notice of Privacy Policies, please fill out the following:

I, _____, have requested and received a copy of this office's Notice of Privacy Policies.

Print Name: _____**Date:** _____

Signature: _____

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:

O Individual refused to sign O Communication barriers prohibited obtaining the acknowledgement

O An emergency situation prevented us from obtaining acknowledgement O Other (please specify)

_____

Jupiter Dental Care Insurance & **Self-Pay** Patients

We strive to deliver the finest care possible at a reasonable cost to our patients. We appreciate the trust and confidence you have placed in us, and because we value you as a patient, we want to ensure that you have a clear understanding of our Privacy Act and payment policy.

Please review our privacy and financial policy below. Our patient service representative will be happy to answer any questions or to address any concerns you may have. After you have read our privacy and financial policy and understand it fully, please sign and return it to us with your health history.

Thank you for choosing Jupiter Dental Care.

Financial Policy Agreement

****Insurance Processing**

Insurance coverage varies from policy to policy, and it is your responsibility to understand what your insurance plan covers. Questions regarding your individual plan should be directed to your human resources department or insurance provider.

As a service to our patients, we assist with insurance processing. We make every effort to maximize your dental benefits, and we will provide you with an **estimate** before any treatment is done. We do not work for the insurance company. **The patient is fully responsible if insurance does not pay.**

Our policy requires co-payments to be **paid at the time of services**. **Our office does not bill**.
If you wish to have pre-authorizations from your insurance company prior to starting treatment and we will be happy to submit it for you. If you decide to proceed with dental treatment without a pre-authorization, you could be responsible for the full cost of treatment.

I, _____, give permission to Jupiter Dental Care to release any insurance information, medical information or any other vital information to another doctor's office, specialist, insurance company and/or collection agency. (May include social security number if it is your insurance member ID)

Missed Appointments/Cancellation Policy/Confirming

We value your time and make every effort to provide treatment in a timely manner and in a few visits as necessary. In order to provide the best services to our patients, we require you make every effort to keep your appointment. Because our time is valuable like yours and other patients could use this time to be seen, you may be charged a cancellation fee for any late cancellations or missed appointment. **As a courtesy**, we confirm your appointment the day before. **It is your responsibility to know your appointment date and time.**

Collection Policy

I understand and agree that a fee will be added to any balance over 90 days and may be sent to the collection agency. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collections of this note. I give permission and to release any information needed to the Collection Agency. Patient is responsible for any credit card fees if wishing to change credit cards after the first credit card is processed. Duplication fees of radiographs apply.

Release appointment or billing information

We may leave a message/text on your cell phone, home answer machine about appointments or billing issues? YES NO
We may speak to a family member about appointments or billing issue? Name of person(s): _____

Patient/Guardian Signature

I have read and understand Jupiter Dental Care Privacy and Financial Policy: This signature below is valid for the entire family.

Patient/Guardian signature: _____

Print Name: _____ **Date:** _____

PATIENT NAME _____ DATE _____

Dental History

Do you have a specific dental problem? Describe_____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional) _____
Date of last full mouth x-rays (18 small films or panoramic) _____

Medical History

Are you under a physician's care now? Why? _____who? _____ Phone#: _____
Have you ever been hospitalized or had major operation? Discuss _____
Have you ever had a serious injury to your head or neck? Discuss _____

Are you taking any medications, pill, or drugs? Please List: _____
Are you allergic to any medications or substances: O Aspirin O Penicillin O Acrylic O Metal O Latex Rubber O Milk O OTHER? _____
Women (Please Check): **O** Pregnant **O** nursing **O** Taking oral contraceptives Discuss: _____

Do you now have or have you ever had any of the following? Please check appropriate boxes:
If yes to any of the starred (*) conditions, please call prior to your appointment…premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart disease/Surgery*			Excessive Bleeding			Osteoporosis			Hepatitis A (infectious)			Psychiatric Care		
Heart Murmur or Defect*			Hemophilia			Bisphosphonates			Hepatitis B or C			Drug Addiction/Alcoholism		
Mitral Valve Prolapse			Methemoglobinemia			Diabetes			Protease Inhibitor			Sleep Apnea		
Rheumatic Fever*			Sinus Trouble			Hypoglycemia			AIDS			Need Premedication?		
Artificial Heart Valve*			Emphysema			Artificial Joint*			HIV Positive					
Hear Pace Maker			Tuberculosis			Kidney Problems			Genital Herpes					
High Blood Pressure			Cancer			Thyroid Disease			Cold Sores					
Low Blood Pressure			Radiation TX			Glaucoma			Fever Blisters					
Bacterial Endocarditis			Chemotherapy						Herpes					

Have you had any other medical issues not mentioned above? Discuss _____
_____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Review by Doctor _____Date _____
History Review and Significant Findings _____

Medical Updates

I have read my Medical History dated: _____and confirm that it adequately states past and presents conditions.

Date	Exceptions	Patient's Signature	Reviewed by:
____	_____None O	_____	Dr. _____
____	_____None O	_____	Dr. _____
____	_____None O	_____	Dr. _____
____	_____None O	_____	Dr. _____
____	_____None O	_____	Dr. _____

DENTAL AND MEDICAL HISTORIES-UPDATES

PATIENT INFORMATION

DATE _____

NAME _____ OMARRIED OSINGLE OMINOR OMALE OFEMALE

SOCIAL SECURITY# _____ DRIVERS LICENSE# _____

ADDRESS_____

BIRTHDATE _____ TELEPHONE _____CELL OR HOME

NAME OF EMPLOYER_____ADDRESS_____

IF FULL TIME STUDENT, SCHOOL NAME _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: **O** PATIENT **O** GAURDIAN **O** SPOUSE **O** PARENT

INSURANCE INFORMATION

MINOR CHILD – may need to complete both blocks for parent information
ADULT – complete primary insured
DUAL COVERAGE? – Fill out both primary & secondary insured

PRIMARY INSURED/IF NO INSURANCE - COMPLETE FOR RESPONSIBLE PARTY	**SECONDARY INSURED**
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME WORK CELL E-MAIL	HOME WORK CELL E-MAIL
BIRTHDAY (XX/XX/XXXX) RELATIONSHIP TO PATIENT	BIRTHDAY (XX/XX/XXXX) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INSURANCE COMPANY	EMPLOYER DENTAL INSURANCE COMPANY
SOCIAL SECURITY# SUBSCRIBER# GROUP#	SOCIAL SECURITY# SUBSCRIBER# GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

_____

NAME ADDRESS CITY/STATE/ZIP TELEPHONE #

Has any member of your family ever been treated in our office? **O** Yes **O** No

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

AUTHORIZATION

I hereby authorize payment directly to Jupiter Dental Care of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hear by authorize Jupiter Dental Care to administer such medications and perform such diagnostic photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

METHOD OF PAYMENT

O Payment in full at each appointment(cash, personal check, credit card)

O Third party credit (Care Credit)

O I wish to discuss the Dental Office's Financial Policy

COLLECTION POLICY

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I have read the above statements (Authorization & Method of Payment) and agree to all terms.

X_____

Patient or Responsible Party **Date**

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?	_____ YES	_____ NO
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
HAVE YOU BEEN EXPOSED TO ANYONE WHO HAS BEEN DIAGNOSED WITH COVID-19 IN THE PAST 21 DAYS?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
HAVE YOU VISITED OR RECEIVED TREATMENT IN A HOSPITAL, LONG-TERM CARE FACILITY, OR OTHER HEALTH CARE FACILITY IN THE PAST 30 DAYS?	_____ YES	_____ NO
ARE YOU OR ANYONE IN YOUR HOUSEHOLD A HEALTH CARE PROVIDER OR EMERGENCY RESPONDER?	_____ YES	_____ NO
WITHIN THE LAST 21 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO

IF SO, WHERE? _____