Thank you so much for selecting my office as a provider for your dental health care needs. I look forward to getting acquainted with you soon! As a new patient there is some necessary information that I will need to obtain from you prior to your appointment. Following these easy steps should make the process go smoothly.

1. Please **print and complete** the Patient Registration & Health History forms, bringing them with you to your dental appointment. These should be completed prior to your arrival at our office**. If it is not possible for you to complete these before you arrive, please arrive an extra 10-15 minutes BEFORE your appointment time** in order to complete the necessary paperwork and registration.

2. If you have Dental Insurance – We will be happy to file your insurance claim for you, and will accept Assignment of Benefits for the estimated portion that your carrier will cover, but to do so we must verify your insurance a few days prior to your appointment. At the time you called our office to schedule your visit, we should have obtained your insurance information but if we failed to do so, please notify us 1-2 business days before your visit. If you are uncertain, please call our office (972) 221-9136 prior to your appointment to verify we have received all necessary information and that your dental insurance has been confirmed.

3. **On the day of your visit**: Office Services, Deductibles and/or Co-Payments are due at the time of your visit and can be made by Visa, MasterCard, Discover, American Express, CareCredit, Personal Check or Cash. Please bring the completed Patient Registration Forms, and your dental insurance card and present it to the receptionist upon arrival. If you do not have a dental insurance card, please let us know. **Be prepared that even with Dental Insurance Benefits, there may be a Deductible and/or Patient Co-Payment that will be due at the time of treatment.**

4. **Important** – We will need to take any necessary X-rays to complete your examination and for a proper diagnosis. If you've seen another dentist within the last 12 months, please bring any current dental x-rays to assist us with your dental treatment. You will need to pick up your x-rays or have them e-mailed to us from your previous Dentist. (For consideration, "Current X-rays" are: Full Mouth Series or Panoramic Films, taken within the past 3 years; Bitewing/Cavity Check Xrays, taken within the past 12 months. Our email address for x-rays is: info@jordancarl.com.

5. If you will be more than 10 minutes late for your appointment, please call our office to verify that your appointment can still be accommodated.

We are looking forward to meeting you and helping you with your dental needs!

Thank You,

Jordan Carl, DMD

Patient Information:

Name_____ Date_____

First MI Last (Preferred Name)

Address_____

City_____ State _____ Zip_____

Mobile # _____ Home_____ Work _____

Birth date _____ Male___ Female___ Social Security Number_____

Email Address_____ Drivers Lic #_____

Single ____ Married ____ Widowed ____ Divorced ____

Patient employed by_____

Whom may we thank for referring you? _____

In case of emergency please contact_____

Phone _____ Relationship_____

Insurance Information:

Insured/Person responsible for account_____

Relationship to the Patient _____Birth Date_____ Social Security #_____

Address (if different from patient) _____

City_____ State_____ Zip_____

Business /Employer Name _____

Insurance Company Name_____ Phone _____

Member ID #_____ Group/Plan #_____

Regarding Insurance:

If you have dental insurance, we will gladly file dental claims for your treatment once your coverage and benefits have been verified**. Your estimated co-pay and deductibles will be collected at each visit.** These numbers are only **estimates**, as your insurance company is unable to provide exact information to us because your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Regardless of what the insurance policy pays or does not pay, I understand that I am fully responsible for any unpaid balance not paid by my insurance. By signing below, I agree to these terms.

I authorize my insurance company to make payments directly to **Jordan Carl, DMD** on my behalf for treatment rendered. I fully understand that quoted costs are **estimates** only, and the patient portion may change if treatment changes or, if the insurance pays more or less than estimated.

Signature of Patient/Parent or Guardian _____ Date: _____

Health History Form (Part 1):

Patient's Name _____Date of Birth _____/_____/_____

Gender: _____ Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today:

_____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe:

_____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam _____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No
If yes,why? _____
Have you ever had surgery? Yes No
If yes, when and what for? Date of surgery:_____ Reason for surgery:_____
Date of surgery:_____ Reason for surgery:_____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy?
Yes No
Describe: _____Date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about?
Yes No
If yes, please explain:

_____

Health History Form (Part 2):

Patient's Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship_____
Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____
Sleep Apnea?	Yes	No	Relationship _____				

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. _____ _____	Yes	No

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No

If yes, which anesthetic? _____ Relationship? _____

Other drug or food allergies not listed above:

_____

Health History Form (Part 3):

Patient's Name: _____ Date of Birth: _____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No

If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No

Emotional disorders? Yes No

Marijuana? Yes No
How often? _____

Do you use:

Alcohol? Yes No
How often? _____

Alcoholism? Yes No

Recreational drugs? Yes No
How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No
If Yes, please explain.

_____

_____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Printed Name of Patient, Parent or Guardian Doctor's Signature

****TO BE INITIALED BY HYGIENIST, DENTAL ASSISTANT OR DOCTOR:**

Date:	Date:	Date:	Date:	Date:
Date:	Date:	Date:	Date:	Date:
Date:	Date:	Date:	Date:	Date:

Financial Agreement:

1. I understand that **all deductibles and co-pays are due at the time of my appointment**. I understand any balances left on my account after insurance pays are my full responsibility.

    * We will gladly file dental claims as a courtesy to our patients. We will accept assignment for payment as long as the patient agrees to pay the balance after insurance has paid. We try our best to **estimate** co-pays & deductibles that are due; however, it is impossible for us to know every insurance plan. We ask our patients to be proactive in knowing how their insurance plan pays and if necessary, be willing to contact the insurance company on their own behalf in order to resolve a claim dispute.

2. There will be a $35 fee for returned checks. In the event of a returned check, I understand that I will no longer be able to pay by check in the future.

3. I understand that after 90 days, regardless of whether my dental insurance claim has been paid or not, my account must be paid in full. Any account left past due or unpaid will be subject to being turned over to a Collection Agency. If it becomes necessary to take these additional steps to collect, I understand that I will be held responsible for all costs incurred (i.e. collection fees, court costs, attorney fees, etc.) Further, I understand that by allowing my account to fall delinquent to these measures I may jeopardize and possibly sever my professional relationship with this practice.

4. I understand that when an appointment is made for me, the time is held specifically for me. I will give a 24 HOUR NOTICE if I need to cancel or change my appointment. If this advance notice is not given, I understand that I will be charged $55 for each appointment hour of time that was held for me or my family member(s). I understand that should I habitually fail to show for appointments, arrive late or cancel without 24 hours notice, I may compromise my professional relationship resulting in dismissal from the practice.

Our office accepts Cash, Personal Checks with proper ID,
Care Credit*, and all Major Credit Cards for payment.

Patient/Parent Name Printed: _____

Patient/Parent Signature: _____

Date: _____

Consent for Treatment:

X-Ray Policy: X-rays are necessary to 1) Look for decay between the teeth; 2) Check for bone loss; 3) Check for decay under fillings; 4) Look for cysts or infection and at the root tip; 5) examine the area before starting a procedure. It is Dr. Carl's responsibility to provide a comprehensive evaluation to every patient, which cannot be done without the proper diagnostic tools available. Some insurance companies may impose limits regarding the types and frequency in which some x-rays are taken. Should my insurance company decline coverage for these x-rays I understand that regardless of their coverage I will be responsible for the fees associated with this service.

If I decline the recommended x-rays, I understand that I will be required to sign a release of liability that states I fully understand that there are conditions that cannot be diagnosed without the proper x-rays and I will not hold Dr. Carl liable for any condition which may present itself and left undiagnosed without proper x-rays. I hereby authorize Dr. Jordan Carl or designated staff to take x-rays, study models, or other aids deemed appropriate by Dr. Jordan Carl to make thorough diagnosis of my special dental needs.

I have read the above information regarding x-rays and fully understand Dr. Carl's philosophy.

Patient or Guardian_____ Date _____

Upon examination and diagnosis, I authorize Dr. Carl to perform all recommended treatment mutually agreed upon by me, to employ proper care. I understand that Dr. Carl and/or designated staff will discuss home care instructions, complications and/or post-treatment needs. I also understand I can ask for complete explanation of any possible complications.

I agree to use anesthetic, sedatives and other medication as deemed necessary. I understand anesthetic agents can have certain risks. If I am given a prescribed medication, I will take it as directed. I will consult with the pharmacist about drug interactions with other medications I may be currently taking. I also understand it is not advisable to operate a vehicle or hazardous device while taking prescribed pain medications.

If I elect to postpone or decline treatment that has been recommended by Dr. Carl, I understand that my future treatment can become more extensive, more costly, lead to tooth loss or contribute to other health problems.

Insurance may limit or exclude services they pay, but Dr. Carl will not dictate my level of care by these limitations.

Patient or Guardian _____Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patients of Jordan Carl, DMD

HIPPA is the Health Insurance Portability and Accountability Act. We are restricted from revealing to anyone that you or a member of your family is a patient or being treated in our office without your consent. This restricts us from: Sending your impression(s) and/or dental appliance(s) for fabrication and/or repairs to our laboratory and technicians; Presenting your checks to the bank or processing your credit card payment; Referring or sharing treatment information, models, diagnostic records, and or copies of dental x-rays with other healthcare providers to include, but not limited to your personal physician, orthodontist, oral surgeon, etc.; Filing and processing an insurance claim with your insurance company; Making personal contact and confirming dental appointments with contact information that you have provided to us. This can include, but is not limited to postcard/mail, telephone, voice mail, e-mail, leaving messages with other person(s) at home or work number, etc.

Signing the HIPPA consent form will enable us to operate normally with the care and business activities of delivering dental services and establishing the framework for compliance with the act. We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of Dr. Jordan Carl's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

The following person(s) are allowed to pick up dental x-rays or other similar forms of health information on my behalf, and you may disclose any or all of my care with them.

Name	**Relationship**	**Phone**
Name	**Relationship**	**Phone**

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details*_____

_____ _____

Employee signature Date