2752 Pleasant Road
Suite 106
Fort Mill, SC 29708
803.548.4353
info@jasperdentistry.com

We are delighted to welcome you to our practice and are pleased that you have chosen us to serve your dental needs. We are serious about providing superior dental care and we are proud of our dedication to our patients. Our goal is to help you look and feel your very best through excellent dental care.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your visit to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer your questions and to assist you at any time.

Please complete the enclosed documents and bring them with you to your appointment. ***If you have dental insurance, be sure to e-mail, mail, or bring your insurance card and your benefits booklet before your scheduled appointment.***

We look forward to meeting you and serving your needs. Thanks again, for choosing our dental practice.

Michele M. Jasper, DDS

Notice to Parents/Legal Guardians*: Patients under the age of 18 must be accompanied by a parent or legal guardian for all appointments. This also applies to patients 18 or older who are covered on their parent's insurance for their first appointment.*

Note: If you have had dental x-rays within the past year, please have them forwarded to our office prior to your appointment. If we do not have them at the time of your appointment, it will be necessary to take new ones.

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

1. PATIENT INFORMATION:

Sex: ____Male ____Female Birthdate: _____ Social Security #: _____

Marital Status: ____Married / _____Single / _____ Divorced / _____Separated / _____Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Would you like to receive CONFIRMATIONS via Text Message? **Y N**

Email: _____ Would you like to receive CONFIRMATIONS via Email? **Y N**

Employment Status: ____ Employed / ____ Retired / ____ Full time Student

Employer: _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____

2. RESPONSIBLE PARTY / IF "SELF" THEN CHECK HERE ____ & SKIP TO SECTION 3:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (Home / Work / Cell - please circle one)

Sex: ____Male ____Female Birthdate: _____ Social Security #: _____

3. INSURANCE INFORMATION:

Name of Insured: _____ Relationship to insured: _____

Insured Social Security #: _____ Insured Birthdate: _____

Employer: _____

Insurance Company:_____ Insurance ID#: _____

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MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: _____
Are you taking and medications, pills or drugs?	O Yes O No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other meds containing bisphosphonates?	O Yes O No	If yes, please explain: _____
Are you on a special diet?	O Yes O No	If yes, please explain: _____
Do you use tobacco?	O Yes O No	
Do you use controlled substances?	O Yes O No	If yes, please explain: _____
Have you ever tested positive for COVID-19?	O Yes O No	If yes, Date : _____

Women: Are you…

Pregnant? O Yes O No Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa Drugs
O Other If yes, please explain: _____

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

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Arthritis/Gout	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Artificial Heart Valve	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Joint	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Asthma	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Blood Disease	O Yes O No	Fainting Spells/ Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Transfusion	O Yes O No			Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Breathing Problem	O Yes O No	Frequent Cough	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Bruise Easily	O Yes O No	Frequent Diarrhea	O Yes O No	Liver Disease	O Yes O No		
Cancer	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Stroke	O Yes O No
Chemotherapy	O Yes O No	Genital Herpes	O Yes O No	Lung Disease	O Yes O No	Swelling of Limbs	O Yes O No
Chest Pains	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No	Thyroid Disease	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Hay Fever	O Yes O No	Osteoporosis	O Yes O No	Tonsilitis	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Attack/Failure	O Yes O No	Pain in Jaw Joints	O Yes O No	Tuberculosis	O Yes O No
Convulsions	O Yes O No	Heart Murmur	O Yes O No	Parathyroid Disease	O Yes O No	Tumors or Growths	O Yes O No
		Heart Pacemaker	O Yes O No	Psychiatric Care	O Yes O No	Ulcers	O Yes O No
						Venereal Disease	O Yes O No

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 _____ DATE _____

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DENTAL HISTORY

Patient name _____ Date of Birth _____

Reason for this visit _____

Last dental visit (date) _____ Frequency of dental visits _____

Previous dentist (name and location) _____

Have you had a complete series of dental films/x-rays taken? _____ When? _____

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing or flossing? _____

Are your teeth sensitive to hot or cold? _____

Does food get caught between teeth? _____ If yes, which area of the mouth? _____

Have you had periodontal (gum) treatment? _____ If yes, date of periodontal (gum) treatment: _____

Do you have any sores or lumps in your mouth? _____

Have you ever had any head, neck or jaw injuries? ____ If yes, date? _____

Have you ever experienced any of the following problems in your jaw? Clicking, ear pain, difficulty chewing, difficulty opening or closing? If so, which of these? _____

Do you clench or grind your teeth? _____

On a scale of 1-10 how anxious are you in regards to having dental work done? _____

Do you wear dentures or partials? _____ If yes, date of placement?_____

Have you had orthodontic treatment? _____ If yes, date of completion? _____

Do you wear retainers? _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____

Jasper Dentistry

2752 Pleasant Road, Suite 106, Fort Mill, SC 29708

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name:	**Date of Birth:**

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must complete and sign this form. Signing this form will only give information to family members indicated below.

I authorize Jasper Dentistry to release my medical and/or billing information to the following:

1. Name: _____Relationship to Patient: _____

2. Name: _____Relationship to Patient: _____

3. Name: _____Relationship to Patient: _____

4. Name: _____Relationship to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

I understand I have the right to revoke this consent in writing.

Signature:	**Date:**

NOTICE OF PRIVACY PRACTICES

By **signing** this **form**, I _____ acknowledge that I have received the **Notice of Privacy Practices**. This **Notice** describes in detail how we might use or disclose your protected health information. Also discusses your rights and our duties with respect to your protected health information.

Signature: _____ **Date**: _____

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FINANCIAL POLICY
1.14.2020

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your dental health.

The following information is the financial policy for this office. If you have questions about our payment policies please do not hesitate to ask.

As a courtesy to our patients, we will process your insurance claim for reimbursement, provided you have given complete and accurate information. For copayments, deductibles, non-covered expenses, or if you do not have insurance, payment is due at the time services are rendered. We accept cash, personal checks (which may be scanned electronically), debit cards, MasterCard and Visa.

Your insurance policy is a contract between you, your employer, and the insurance company. WE ARE NOT A PARTY TO THAT CONTRACT. Our relationship is with YOU, not the insurance company. INSURANCE IS FILED AS A COURTESY TO YOU. All charges are your responsibility whether or not insurance pays.

If insurance has not paid within **30 days,** you will be responsible for the balance due. A statement will be sent to you with the due date noted. If you are uninsured balance is due at the time services are rendered.

Should your account become delinquent, it will begin to accrue finance charges. You agree to reimburse us the fees of any collection agency, which is based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney fees, which we incur in such collection efforts. Once turned over to this agency, any questions regarding your account will be directed to them. Please note, once sent to collections, all scheduled appointments for all persons on your account will be cancelled. Should you require emergency appointments or any other appointments you will be served but on a cash-basis only.

In regard to **minor children**, all charges are the responsibility of the parent who is listed as the responsible party on the child's Patient Information Form. In the event of a divorce or separation, we DO NOT decide custody issues. The responsible party (parent) must pay all balances and is responsible for obtaining reimbursement from the other parent.

Again, thank you for choosing us as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

I have read and understand the above financial policy and agree with its contents.

Signed & dated and entered into patient's file

REQUEST FOR INFORMATION FROM PREVIOUS DENTIST

DR: _____

_____

_____

DR. PHONE: _____ **FAX: _____**

DR. EMAIL: _____ _

PATIENT NAME(S): _____

_____

Please use this letter as authorized to forward a copy of **X-RAYS, TREATMENT/CHART NOTES, AND PROBINGS** for the patient(s) listed above to the following:

EMAIL info@jasperdentistry.com
MAIL: Jasper Dentistry
2752 Pleasant Road
Suite 106
Fort Mill, SC 29708

Your prompt attention to this matter is greatly appreciated. If you have any questions regarding this form, please contact us 803.548.4353.

_____SIGNATURE **_____ DATE**