SOCIAL CIRCLE DENTAL
NEW PATIENT REGISTRATION

ABOUT YOU

Patient Name:________________________________

I prefer to be called:___________________________

Birthday:__________ Age:____ SSN:__________

Email Address:_____________________________

Home Address: _____________________________

____________________ City:_______________

State:_____ Zip:________ Sex: Male___ Female___

Best Contact #:_________________Text ___Call ___

Alternate #:________________Leave Message:Y / N

Drivers License #:___________ We will make a copy.

Employer:___________________________________

Occupation:_________________________________

How did you hear about our office?______________

____

Whom may we thank for referring you?___________

____

Previous Dentist:_____________________________

Last Visit to Dentist:__________________________

Person Responsible For Account:_________________

SPOUSE INFORMATION

His/Her Name:_______________________________

Date of Birth:__________ Phone #:______________

DENTAL INSURANCE

We do not file any type of medical or secondary insurance.

Ins. Company Name:___________________________

Address:_______________________________________

______________State:_____ Zip:___________

Phone #:_________________Individual Policy? Y/N

Policy Holder:_________________________________

Relationship:___________Their DOB:___________

ID# or SSN:________________-NOT THE GROUP #

Insured's Employer:____________________________

Group #:_________________ Please provide card.

DENTAL HISTORY

Why have you come to the dentist today:_________

____

Are you currently in pain? Y / N Area:___________

Your current dental health is:__________________

Have you ever had a serious/difficult problem associated with any previous dental work? Y / N

Do you floss daily? Y / N Brush Daily? Y / N

Type of bristles on your toothbrush?_____________

Have you ever had gum disease/treatment? Y / N

Do you your gums ever bleed? Y / N Ever itch? Y / N

Do you now or have you ever experienced pain/discomfort in your jaw joint? Y / N TMJ? Y / N

Are your teeth sensitive to hot Y / N or cold Y / N ?

MEDICAL HISTORY

Physician's Name:____________________________

Phone #_______________ Last Visit:___________

Your current physical health is:________________

Are you currently under the care of a physician? Y/N

Please explain:________________________________

____

Do you smoke or use tobacco in any other form including vaping? Y / N

Do you have tattoos or piercings? Y / N

Are you allergic to any drugs/materials? Which ones?_____________________________________

Have you had any metal rods, pins or plates placed in your body? Y / N If yes when:________________

Do you wear a cardiac pacemaker or have you had heart surgery? Y / N If yes when:_______________

WOMEN: Are you using a prescribe method of birth control? Y / N Are you pregnant or nursing? Y / N

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Are you required to take any pre-med (antibiotics) before dental work? Y / N If yes what:___________

Are you taking any prescription or over the counter drugs? Y / N Please provide a list of all current medications:______________________________

____

Have you ever taken bisphosphonate ? Y / N

Do you take Vitamin C daily? Y / N

Do you take a daily blood thinner/aspirin? Y / N

Please list any serious medical conditions that you have ever had/have. ______________________

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

PLEASE CHECK YES / NO FOR EACH OPTION

YES NO

- ☐ ☐ Abnormal Bleeding/Hemophilia
- ☐ ☐ AIDs related complex
- ☐ ☐ Allergies or Hives
- ☐ ☐ Alcohol/Drug Abuse
- ☐ ☐ Anemia
- ☐ ☐ Angina Pectoris
- ☐ ☐ Arthritis
- ☐ ☐ Artificial bones/joints/valves
- ☐ ☐ Artificial Prosthesis
- ☐ ☐ Asthma Is it Active ? Y / N
- ☐ ☐ Autism
- ☐ ☐ Blood Disease
- ☐ ☐ Blood Transfusion
- ☐ ☐ Cerebral Palsy
- ☐ ☐ Chicken Pox
- ☐ ☐ Colitis
- ☐ ☐ Chemotherapy(Cancer, leukemia)

YES NO

- ☐ ☐ Congenital Heart Defect
- ☐ ☐ Diabetic
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Disability ___________
- ☐ ☐ Drug Addiction
- ☐ ☐ Emphysema
- ☐ ☐ Epilepsy/Seizures
- ☐ ☐ Excessive bleeding
- ☐ ☐ Fainting Spells
- ☐ ☐ Fever Blisters
- ☐ ☐ Frequent Headaches
- ☐ ☐ Glaucoma
- ☐ ☐ Hay Fever
- ☐ ☐ Heart Attack / Surgery
- ☐ ☐ Heart Failure
- ☐ ☐ Heart Murmur
- ☐ ☐ Head Injuries
- ☐ ☐ Hepatitis / jaundice
- ☐ ☐ Herpes
- ☐ ☐ High Blood Pressure
- ☐ ☐ Joint Replacement

YES NO

- ☐ ☐ Kidney Disease
- ☐ ☐ Liver Diesease
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Lupus
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Nervous Disorder
- ☐ ☐ Pacemaker
- ☐ ☐ Psychiatric Treatment
- ☐ ☐ Radiation Treatment
- ☐ ☐ Respiratory Disease
- ☐ ☐ RheumaticScarlet Fever
- ☐ ☐ Sinus Problems
- ☐ ☐ Sickle Cell Disease
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tonsillitis
- ☐ ☐ Tuberculosis (TB)
- ☐ ☐ Tumors or Growths
- ☐ ☐ Ulcers
- ☐ ☐ Venereal Disease
- ☐ ☐ X-Ray Cobalt Treatment

The information and health history and preceding answers are true and correct to the best of my knowledge. I authorize and give consent to preform dental services agreed between doctor and patient and/or guardian to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I agree that the regardless of insurance coverage, I am responsible for payment of services rendered. If I ever have any changes in my health or my medication changes I will, without fail, inform the doctor at my next appointment.

____

Signature of Patient/Guardian Date

SOCIAL CIRCLE DENTAL

FINANCIAL AND HIPPA POLICIES

Office Financial Policy

As a professional courtesy to our patients, we will file insurance.
Please keep in mind that insurance company percentages are only an estimate and not a guarantee of benefits.
Any dispute regarding insurance is your responsibility and not that of our office.

Some insurance companies base the amount of benefits on a chart or schedule of fees arbitrarily developed by third-party payers. For that reason, you may receive lower percentage of the reimbursement level indicated in your dental plan.

Please keep in mind that if you are required to choose a dentist from a list, make sure our office is on it. We only participate with a few. Also, if you can go outside of network with your policy, your insurance may be reduced in our office.

Payment Policies

All payments are due at time of treatment. For your convenience we accept cash, personal checks, Visa, Master Card, Discover and Care Credit.
THERE WILL BE A $25.00 SERVICE CHARGE ON ANY RETURNED CHECKS!
You are responsible for all the fees incurred at this office, not your insurance company. You are responsible for all fees incurred at this office including collection fees and court cost. Therefore those charges are as follows:

ACCOUNTS WITH BROKEN APPOINTMENT OR LATE CANCELLATIONS OF APPOINTMENT WILL BE CHARGED $25.00 FOR EVERY HALF HOUR OF THEIR APPOINTMENT TIME.

YOU MUST GIVE A 24 HOUR NOTICE. The charge will have to be paid before another appointment can be scheduled.

HIPPA Policy

Social Circle Dental is completely HIPPA compliant. Our commitment is to our patient's privacy. However, we must divulge some private information in order to file insurance claims, accept payment, confirm, remind of appointments and discuss treatment options. This is not the full disclosure of the privacy practice of Social Circle Dental. A full disclosure is available for patients to read in our office.

I have read the above privacy practice of Social Circle Dental. I understand that the full notice of Privacy practice is posted in the office and that I may request a paper copy of the full notice. All of my questions about the privacy of my health information have been answered to my satisfaction.

I understand that unless revoked in writing this agreement will be in good standing between myself and Social Circle Dental and cannot be disputed.

____

Patient Name Printed

____

Patient/Guardian Signature Date

Don D. Jones, Jr. D.M.D.
Social Circle Dental

RELEASE FORM FOR DENTAL RECORDS AND PERSONAL HEALTH INFORMATION

I ________________________________ DOB:____________________
(PATIENT NAME) (MM/DD/YYYY)

do hereby authorize Social Circle Dental to send a copy of my dental x-rays, dental records, and identifying personal health information to any other requesting office that I have chosen to see or been referred to.

I understand that this constitutes a release of my health records and information to a different provider and that this agreement clears Social Circle Dental of any responsibility as long as the information sent is received by the requested provider.

If a provider (other than Social Circle Dental) that has either requested by the patient or the patient has been referred out to calls and also request the insurance information (if patient has coverage) for

____;
(PATIENT NAME)

- ☐ I as the patient, or patients legal guardian, **DO** consent for Social Circle Dental to release my personal health information described above to any requesting provider.

- ☐ I as the patient **DO NOT** consent for Social Circle Dental to release any of my personal information describe above to any requesting providers and understand this means I have to **PICK UP MY PERSONAL INFORMATION IN OFFICE INCLUDING X-RAYS, REFERRALS, AND ANY OTHER DOCUMENTS THAT MAY BE NEEDED OUTSIDE OF SOCIAL CIRCLE DENTAL FOR ANY REASON.**

I ACKNOWLEDGE THAT THE FOLLOWING PERSON(S) LISTED BELOW (IF ANY) ARE ALLOWED ACCESS TO MY PERSONAL HEALTH/DENTAL INFORMATION. MY DENTAL RECORDS, X-RAYS, PROPOSED TREATMENT, AND FINANICAL OBLIGATIONS MAY BE DISCUSSED AND RELEASED TO THEM:

____
Name Printed Relationship

____
Name Printed Relationship

I understand that **unless revoke in writing**, this agreement will be in good standing between Social Circle Dental and myself and cannot be compromised or disputed otherwise.

____ ________________________
Patient Signature (Legal Guardian if under 18yrs of age) Date

OZONE CONSENT:

This form is to authorize Dr. Donovan D. Jones, Jr., DMD and staff to provide treatment for:

Patient Name____

Utilizing, but not limited to the following procedures:

- Clinical and Radio-graphic (x-ray) examinations

- The use of ozonated water, ozonated olive oil, ozonides and oxygen/ozone gas mixtures to disinfect the mouth, soft tissues, (gums, cheeks, tongue and associated structures) tooth structure, root canals, dental implants, extraction sites, and any infections in the oral cavity or associated structures as defined by the American Dental Association (ADA) definition of Dentistry.

- Dental Cleaning Procedures, including: a) scaling the teeth (removal of hard deposits) with hand instruments or ultrasonic. b) Root Planning of the teeth. (Removal of hard deposits from root surfaces) c) Polishing the teeth.

- Removal of tooth structure and previous restorations as required for bite adjustments, restoring cracked, fractured or decayed tooth structure.

- Obtaining impressions of the oral tissues for removable or permanent appliances such as: night guards, dentures, removable partial dentures, bridges, crowns or for any other type of appliance required for my treatment.

I understand that unforeseen conditions may arise during proposed treatment which may require a change in the procedure being performed and I will be notified of any of these changes before preceding to the next step. I consent to the referral of any additional procedures that may be necessary to complete the procedure. (For example: during the removal of decay from the tooth for a filling, the nerve may be exposed necessitating a root canal or extraction **OR**, a piece of tooth, filling material or appliance can be aspirated requiring a surgical procedure) I understand that the final decision of the options provided will be up to me and accept responsibility for what may come with the decision.

I consent to the injection and administration of local anesthetics, oxygen/ozone gas, homeopathic, or any other agent that may be necessary for the treatment of my condition(s). I understand that there is an element of risk inherent in the injection and administration of any inject-able agent. These risks include, but are not limited to: Herxheimer reactions, (healing crisis) adverse drug reactions, allergic reactions, cardiac arrest, tachycardia, swelling, bruising, pain, transient or permanent nerve damage, asthmatic reactions, needle tract infection and other unspecified injuries.

I consent to be seen by Dr. Donovan D. Jones, Jr., DMD, and I am aware that there are risks in any dental procedure that is performed. I recognize that the practice of dentistry is not an exact science and I understand that there has been no warranty or guarantee that the treatment and results I am seeking will be successful.

____ ____________

Patient or Guardian Signature Date

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OralID™

Oral Cancer Screening Consent Form

Our office strives to bring its patients state of the art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID™ examination will allow us to visualize any mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless, and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at risk?

- Age 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors please feel free to talk to our dental staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

Our office charges $30.00 per screening with the OralID™. We will attempt to bill your insurance, however you will be responsible for any unpaid amount or denied amount by your insurance company.

☐ Yes! I request that your staff perform an examination with the OralID™. I accept financial responsibility for this examination as mentioned above.

☐ No! I prefer to not have this examination at this visit.

Signature | Printed Name | Date