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#: ________________________

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.

Question	Answer	
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: ____

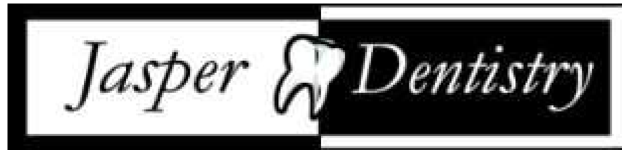
Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Breathing Problem	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Bruise Easily	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Cancer	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Chemotherapy	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chest Pains	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsilitis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Convulsions	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
				Psychiatric Care	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 ________________



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 ___________________

CONSENT FOR DENTAL TREATMENT

Patient's Name: ____

1. **Treatment:** I understand that I may need dental treatment performed either now or in the future. Please do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting, you acknowledge your willingness to accept known risks and complications, no matter how slight the probability of occurrence. I understand that proper maintenance (such as proper brushing, flossing, and other dental aids) is my responsibility to keep dental restorations healthy, and my failure to keep up with regularly prescribed cleanings will void any warranty on my dentist's work.
2. **Drugs and Medications:** I understand that antibiotics, analgesics, anesthetics, and other medications may be needed to perform the necessary treatment. These can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea, and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Pain at injection site and loss of taste or function in an area are also known side effects.
3. **Sealants and Fillings:** I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during the procedure. I understand that care must be exercised in chewing on a new restoration to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling. I realize that sealants and fillings are not "permanent" and usually require periodic replacement.
4. **Crowns, Bridges, Veneers, and Bonding:** I understand that it is sometimes not possible to exactly match the color of natural teeth. I further understand that I may be wearing temporary restorations that are prone to loosening and may need recementing. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication of the restoration. I understand I may need further treatment by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.
5. **Periodontal Disease:** Periodontal disease can be serious condition, causing gum and bone inflammation and /or loss and may lead to loss of permanent teeth. If treatment is necessary, the options have been explained to me, including deep cleaning, gum or osseous surgery, extraction of teeth. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.
6. **Temporomandibular Joint (TMJ) Dysfunctions:** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the TMJ subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually temporary in nature and well tolerated by most patients. I understand that should the need for treatment arise, I will be referred to a specialist for treatment, the cost of which is my responsibility.
7. **Changes in Treatment Plan:** I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor. I certify that I understand English. My signature below signifies that I understand the treatment that is proposed, together with the known risks and complications associated with the treatment. I hereby give my consent for the treatment that may be presented to me.

____

Patient's (or Legal Guardian's) Signature Date

____

Doctor's Signature Date

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**: _____________________

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

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

Patient Name: ____

DOB: ________________________

Previous Dentist: ____

Address: ____

____

Phone: ____

Email: ____

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
FAX: 803-620-1560
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 ________________________________