JC Dental

Patient Information

Patient Name: _____ Date : _____
Last Name Name Initial or Nickname

Sex: _____ Marital Status: _____ Email: _____

Social Security #: _____ Date of Birth: _____

Telephone (home): _____ (work): _____ ext: _____ Best Hour to Call: _____

Preferred Appt. Hours: ☐ mornings ☐ afternoon ☐ evening ☐ anytime Days: ☐ M ☐ T ☐ W ☐ Th ☐ Sat

Address: _____
Street # Apartment City State Zip Code

Emergency: _____ Telephone: _____
Name Relationship to Patient

Health Information

Date of your last dental visit: _____ Reason for this visit: _____

Have you had or have any of the following diseases? Please check-off those which apply:

☐ HIV	☐ Excessive Bleeding	☐ Liver Disease	☐ Stomach Problems
☐ Allergies to medication or Latex, other: _____ _____	☐ Fainting Spells	☐ Mental Health Disorders	☐ Stroke
	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
	☐ Growths or Tumors	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Headaches or Migraines	☐ Osteoporosis	☐ Ulcers
☐ Arthritis	☐ Head Lesions	☐ Pacemaker	☐ Venereal Diseases: _____
☐ Asthma	☐ Heart Attack	☐ Pregnancy—Due Date: _____	☐ Allergy to Codeine
☐ Cancer	☐ Heart Disease	☐ Radiation Treatment	☐ Allergy to Penicillin
☐ Diabetes	☐ Heart Murmur	☐ Respiratory Problems	☐ Allergy to Aspirin
☐ Dizziness	☐ Hepatitis type: _____	☐ Rheumatic Fever	☐ Blood Disorders
☐ Do you consume Tobacco?	☐ High Blood Pressure	☐ Rheumatism	☐ Other: _____
☐ Do you consume Alcohol?	☐ Jaundice	☐ Scarlet Fever	_____
☐ Epilepsy	☐ Kidney Disease	☐ Sinus Problems	

- Have you had any complications after a dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency treatment in the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you under medical treatment? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Doctor: _____ Telephone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of Patient, Parent or Representative

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, family member
☐ Dental Office ☐ Yellow Pages/Internet ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of the person or dental office referring you to our practice: _____

JC Dental

JORGE O. CORDOVA INC.

FINANCIAL POLICY

Thank you for choosing us to provide your child's dental care! The following is a statement of our financial policy. If you have any questions or concerns, please do not hesitate to ask our office staff.

DENTAL INSURANCE: We participate with the following insurance plans: Cigna PPO, Delta Dental (Premier or POS), Guardian PPO, Tricare, United Concordia, DH (AETNA PPO), Demtemax, Connection Dental (GEHA), Mavarest Dental, Anthem PPO 100/200/300, Ameritas PPO (Principal), Solstice, and MetLife PDP. Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of benefits is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. Fees for non-covered benefits, deductibles and copayments are due at time of treatment. For patients without insurance coverage, full payment is expected at time of service.

PAYMENT POLICY: We accept cash, check, debit cards, and all major credit cards. A $30.00 fee will de charged for a bank returned check.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payments, with NO EXCEPTIONS.

COLLECTION FEES: **In the unlikely event that my account is sent to a collection agency, I understand I am legally responsible for the 29% collection fee, plus the balance on my account.** We understand temporary financial problems may affect timely payments and encourage you to communicate with the office immediately so we may assist you with your account.

BROKEN OR MISSED APPOINTMENTS: Broken appointments prevent others from receiving the dental care they deserve and the time they need. **A fee of $50.00 will be charged for broken appointments and appointments that are cancelled without 24 hours' notice.** We also reserve the right to terminate professional care of any patient who consistently breaks appointments.

I authorize you to charge payment to the credit card listed below:

Amex/Discover/MC/Visa Number _____ **Exp.** _____

Form Completed By:

Print Name: _____ **Are you legally responsible for this child? Yes/No**

Sign Name: _____ **Date:** _____

JC Dental

Jorge O. Cordova Inc.

Consent for dental treatment

I, _____, authorize the doctors of Jorge O. Cordova Inc. / JC Dental and their dental staff to perform an oral exam, a prophylaxis (dental cleaning) and an routine application of topical fluoride, should it be necessary. Dental radiographies may be necessary, according to the directives established by the American Dental Association, to complete the diagnosis of a dental condition. Should a treatment plan be needed, I authorize the doctors to choose the techniques and assistance that they deem necessary during treatment. I understand that I have the right to be provided with answers to any questions that may arise during the course of the diagnosis and treatment.

I understand that I have the right to revoke my consent to treatment at any time, and that this consent will be effective until I resolve to terminate the such.

The nature and the risks of the procedures have been explained in their entirety and I understand them. I recognize that the practice of dentistry is not an exact science and I have not been made guarantees as to the results of the proposed procedures.

Name: _____ Are you responsible fore this minor? Yes/No

Signature: _____ Date: _____

JC Dental

JORGE O. CORDOVA INC.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to the use and disclosure of you health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy before you decide whether or not to sign this form. The Notice explains the extents to which information may or may not be used. We encourage you to read it carefully before signing this document.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, and if such a change should occur, we will provide you with a copy of the new document. Those changes may apply to any health information that we maintain.

You may obtain a copy of our Notice Of Privacy Practices, including any revisions of our Notice, at any time by contacting the office at (973) 627-2121, by email at receptionjcdental@yahoo.com, or by fax at (973)-627-2088. Mail requests may be sent to: Jorge O. Cordova, Inc., P.O. Box 318, Rockaway, NJ, 07866.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this signed consent before receipt of revocation, and that we reserve the right to decline to treat you based on either failure to sign consent or upon signing revocation of this consent.

Signature

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 form, I am giving consent to your office to use and disclose my health information by the guidelines outlined in the Notice of Privacy Practices.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to the Patient: _____