JASON A. DUNVILLE, DDS

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The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date:_____

Name: _____ ☐ Male ☐ Female
First Mi Last Mr. Mrs. Ms Dr

Name I prefer to be called:_____ E-mail Address: _____

Birthdate:_____/_____/_____ Age:_____ SS #:_____ ☐ Single ☐ Married

Home Address: _____ ☐ Partnered ☐ Widowed
Apt/Condo #

_____ ☐ Divorced/Separated
City State Zip

Cell #: (_____)_____ Work #: (_____)_____ Ext: _____

Home / Other #: _____

Employer: _____

Occupation: _____

Whom may we thank for referring you?_____ Other family members seen by us: _____

Previous / Present Dentist: _____

Emergency Contact:

His / Her Name:_____ Relation: _____

Cell #: (_____)_____ Work / Other #: (_____) _____

2 SPOUSE INFORMATION

His / Her Name:_____ Employer: _____

Cell #: (_____) _____ SS #:_____ Birthdate:_____/_____/_____

3 INSURANCE

PRIMARY DENTAL INSURANCE

Policy Holder: _____

Birthdate: _____

Insurance Co. Name: _____

SECONDARY DENTAL INSURANCE

Policy Holder: _____

Birthdate: _____

Insurance Co. Name: _____

Acknowledgement of Receipt of Notice of Privacy Policies

I, Name (print) _____, have received a copy of Jason A. Dunville, D.D.S.'s Notice of Privacy Policies.

Signature _____ Date _____

This information is intended as advisory in nature and should not be considered as legal advice nor is it substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed. The Federal HIPAA privacy compliance requirements are explained in this binder. When you develop your HIPAA compliance policy, incorporate whatever is necessary to address state law requirements as well.

Continued on the back.

4 MEDICAL HISTORY

Do you have a personal physician? Yes No Physician's Name: _____

Phone #: (_____)_____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No Please Explain: _____

Do you smoke or use tobacco in any other form? Yes No Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter drugs? Yes No Please list each one: _____

_____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding / Hemophilia
Y N AIDS
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N CPAP Machine
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hepatitis Type_____
Y N Herpes
Y N Fever Blisters
Y N High Blood Pressure
Y N HIV
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Diagnosed with Sleep Apnea
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Sulfa
Y N Tetracycline

Please list any other drugs / materials that you are allergic to : _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week#_____ Are you nursing? Yes No

IMPORTANT

Do you take any type of prescription blood thinning medications or any type of aspirin daily? Yes No

Please list: _____

_____

Have you ever had bone cancer? Yes No

5 DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require premedication before dental treatment? Yes No
(for patients with prosthetic joints, orthopedic implants, or a heart condition)

Your current dental health is: Good Fair Poor

Are you happy with the way your smile looks? Yes No

Are you interested in Invisalign Whitening Cosmetic Options Orthodontics

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment, with my informed consent.

I, the undersigned, a patient of Jason A. Dunville, DDS, request and authorize Jason A. Dunville and his associates, employees, assistants of who may refer me to, to administer such treatment as is medically necessary. I voluntarily consent to said medical/dental care, evaluation and treatment. This consent would include medical/dental services, care diagnostic procedures (would include, but not limited to radiology), and/or treatments as Jason A. Dunville and his associates, employees, assistants or who may refer me to deems reasonable and necessary. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover, including all finance/late charges that may occur. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment of examination rendered, to my insurance company.

Signature: _____ Date: _____

JASON A. DUNVILLE DDS PC
GENERAL DENTISTRY

OFFICE POLICY REGARDING DENTAL INSURANCE

As a courtesy to our patients, we are happy to file your dental insurance claims for you at the time of your treatment. So that you fully understand how the process works, please read the following.

- You must bring a current DENTAL insurance card. (Medical insurance cards are not the same).
- We will call to verify your coverage at the time of your appointment. You are responsible for providing us with your benefit coverage.
- After Dr. Dunville has seen you, you are responsible for paying the full amount your insurance is not estimated to pay.
- We will file the claim for you (electronically). If the x-rays or narratives are needed, we will send those with the claim.
- If, after 60 days, your account remains unpaid by your insurance, you will be responsible for the balance.
- Please keep in mind that ***not all*** services are covered by your insurance, and that it is the ***patient's responsibility to know their benefits.***

Your dental insurance is a contract between your employer, and your carrier (we are a third party). Your employer purchases a fee schedule (UCR schedule) from an insurance company. The amount paid by your insurance company is based on the plan "UCR schedule" your employer purchases. For example, if the insurance company covers 80% of the fee, that is 80% of the "UCR schedule" in the plan, ***not 80% of our fee schedule.*** *Our fee schedule is different from the fee schedule your employer purchased. Of course, the higher the plan your employer purchases, the more the insurance company pays. If you have any questions regarding the "UCR schedule" your employer purchased or specific benefit questions, please contact them directly. The 1-(800) number is typically located on the back of your dental insurance card. You may also contact your Human Resources department.*

In cases of divorced parents, the parent bringing the child to the visit will be deemed responsible for payment. Our office will not become involved in custody disputes over which parent is the responsible billing party.

I authorize payment of benefits directly to the provider, release of all necessary information to the insurance carrier and their representatives. I have read this form and agree to be financially responsible.

_____ _____

Signature of Patient (or parent/guardian, if minor) Date