DR. JARED T. KENT

210 North Lewis Street
LaGrange, Georgia 30240
(706) 882-2551
info@lagrangedentist.com

in

Patient Information

Date _____

Patient's Name _____
Last First Middle Preferred Name

Address _____
Street City State Zip

Home/Cell Phone _____ Birth date _____ Social Security #_____

Email_____ (Check each method of Contact you prefer) ☐Call ☐Text ☐ Email

Employer_____ Occupation_____ No. of Years Employed_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name _____ Birth Date _____ Social Security #_____

Employer _____ Occupation _____ No. Years Employed _____

Cell Phone _____

Whom may we thank for referring you to our office? _____

Responsible Party/ Information

If the patient is a minor (under the age of 18)

Name_____
Last First Middle

Residence _____
Street City State Zip

How long at this address _____Home/Cell Phone _____Work Phone _____

Social Security # _____ Date of Birth _____ Relationship to Patient_____

Employer _____ Occupation _____ No. Years Employed _____

Insurance Information

Primary Carrier Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____

Insurance Co _____ Group No. _____ Insurance Co. Phone # _____

Insurance Co. Address _____

Secondary Carrier Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____Insurance Co. Address_____

Insurance Co _____ Group No. _____ Insurance Co. Phone # _____

Emergency Information

Emergency Contact Name _____ Emergency Contact Phone #_____

Relationship to Patient_____

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MEDICAL HISTORY
PAGE 1

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, too often people forget your mouth is a 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 any medications, pills, or drugs? O Yes O No If yes, please explain: _____
History of Prolia, Boniva (R) or Fosamax (R)? 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 If yes, please explain: _____
Do you use controlled substances? O Yes O No If yes, please explain: _____

Women: Are you
Pregnant/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 Zithromax O Codeine O Acrylic O Metal O Latex O Local Anesthetics
O Other please explain: _____

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

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

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Important Facts and Office Policy Regarding Dental Insurance

Dental Insurance is not to be confused with Medical Insurance. They are two very different products. In the early 1980's dental insurance maximums were generally between $1000 and $1500 per year. The cost of living has dramatically changed for all of us since the 1980's; yet still today **in general** the maximum benefit paid by most dental insurance companies is only between $1000 and $1500 per year.

Dental Insurance Plans are designed to only **cover a portion of your dental expenses** as evidenced by the practice of only paying a percentage of fees which **they determine themselves**. Even though an insurance plan claims to pay 100%, it may be only of a fee much lower than is generally charged for a procedure or group of procedures.

In regards to fees, you will hear the term "UCR", "usual, customary and reasonable" to determine the level of reimbursement. This "sounds good", but do not be misled by this term. This is often very confusing. You should know that "UCR" often varies with different plans within the same company in the same geographic location. This often is deter-mined by the specific plan you or your employer purchases and when everyone is understandably trying to keep premiums low, often this results in a **lower than desirable "UCR" rate**. Too, these do not seem to be updated as frequently as you might think.

Unfortunately, patients who have extensive restorative and surgical needs trying to spread the needed treatment over multiple plan years may suffer unnecessarily as conditions worsen. We offer third party alternative financing if you have a need or are interested and hopefully wish to complete your treatment in a timely manner that best serves your health needs.

Like medical insurance, dental insurance will often times not cover pre-existing conditions, such as missing teeth. Often these plans do not cover for the more desirable fixed or cemented bridge, but may cover removable appliances.

Most dental insurance plans have exclusions and limitations on frequency of treatments. For instance, cosmetic treatments like bleaching and cosmetic veneers are generally excluded. Periodic examinations, radiographs, "cleanings" and fluoride treatments are often limited by frequency and may even have age limitations. Very few plans cover replacing missing teeth with dental implants at this time. Hopefully that will change one day. Plans vary on these points. It is important to know exactly how your plan coverage on these items works.

It is **not uncommon** for an insurance plan to apply "alternate benefits" for a service. For instance, often insurance plans will not pay for major restorative dentistry like the needed crown or inlay and only pay for "regular" fillings. Also, even though we may agree that a tooth colored restoration is best for you, an insurance plan will often substitute their fees for silver/amalgam fillings.

As a courtesy to our patients, we will gladly file your initial claim at no charge. We do these electronically in most instances which will speed up the process. Refiling claims may be subject to a service charge.

These facts are for general use and information to our patients only and **do not imply a guarantee of insurance coverage nor acceptance of all insurance plans in our office. Patients remain fully responsible for all charges regardless of whether or not the insurance plan pays**.

Finally, please be aware that we are not responsible for tracking your insurance benefits, nor are we responsible for determining your current maximum benefits available at any time. Please contact your insurance company or your insurance benefits coordinator at your place of employment if you have questions regarding these issues.

Insurance Authorization:

I hereby authorize insurance payment of benefits otherwise payable to me, directly to Dr. Jared T. Kent. I understand that I am responsible for all costs of dental treatment. I hereby authorize the practice of Dr. Jared T. Kent to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information I have provided on my medical and financial history is correct to the best of my knowledge.

Signature: _____ Date: _____

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PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

(AS REQUIRED BY THE PRIVACY STANDARDS OF THE HEALTH INSURANCE AND ACCOUNTABILITY ACT OF 1996 HIPPA)

I have been advised of the Notice Of Privacy Practices of **Dr. Jared T. Kent's** office, on the date indicated below.

I understand that if any changes are made to this Notice Of Privacy Practices, a revised copy will be posted in the office.

I also understand that if I wish to receive copies of this Notice Of Privacy Practices or if I have any questions with regard to this Notice Of Privacy Practices, I may contact the office manager or write to:

Ashley Barnes
CHIEF PRIVACY OFFICER/COMPLIANCE
LAGRANGE, GEORGIA 30240
1-706-882-2551
FAX 1-706-845-0469
Email: info@drjaredkent.com

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date