On behalf of all our doctors and staff, we would like to personally welcome you to Jamboree Dentistry. The highest compliments we can receive are when our patients show a vested interest in establishing and maintaining optimal oral health and tell everyone about Jamboree Dentistry. Please take a few minutes to tell us how you heard about our practice.

Sincerely-Jamboree Staff
PATIENT INFORMATION FORM

Welcome to our practice! We strive to make each of our patients visits pleasant and comfortable. Our goal is to keep our patients smile beautiful for a lifetime.

PATIENT REGISTRATION INFORMATION:

Patients First Name: __________________________________ Last Name: ___________________________ Nick Name: ___________________________

Sex: □ Male □ Female                  Birthdate: _____ / _____ / ______   Age_______         SSN/SIN: ________-_______-________

Patients Address:__________________________________________________________Apt: ______ City: _______________ State: _______ Zip: ___________

Phone: ______________________________ Cell: _______________________________ Email: ______________________________

PARENT/GUARDIAN INFORMATION:

First Name: ___________________________________________ Last Name: ______________________________

Relationship to Child: □ Mother □ Father □ Stepmother □ Stepfather □ Guardian

Home Phone: ______________________________ Work: ______________________________ Cell: ______________________________

SSN/ID: ______________________________ TDL/DL: __________________ Date of Birth: ______________________________

Address: __________________________________________ Apt: ______ City: _______________ State: _______ Zip: ___________

Work Email: ______________________________ Home Email: ______________________________

Primary Dental Insurance □ Medicaid or Chip # __________________________ □ Private Insurance (see below) □ Self Pay

Policy Holder’s Full Name: __________________________________________ Relationship to patient: __________________________

Birthdate: _______ / _______ / _______ SSN/ID ________-_______-________ Occupation: __________________________

Policy Holder Address:__________________________________________Apt: ______ City: _______________ State: _______ Zip: ___________

Employer Name: ___________________________________________ Insurance Name: ______________________________

Insurance Provider’s Telephone: __________________________ Group #: ____________________ Member ID: ______________________

Preferred Pharmacy Name: ______________________________________ Phone: __________________________ Fax: ______________________

Emergency Contact Name: ______________________________________ Phone: __________________________

Consent:

- I understand the above information is necessary for the patient to receive dental or orthodontic care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

- I authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient’s dental or orthodontic needs.

- I authorize the doctor to perform all recommended treatments, mutually agreed upon by me, to use the appropriate medication and therapy indicated for such treatment in connection with ______________________________ (patient’s name).

- I understand that using anesthetic agents entails a certain risk. Furthermore, I authorize and consent that the doctor chooses and employs the anesthetic necessary to the recommended treatment.

- I understand that it is my responsibility to advise your office of any changes in medical history.
PATIENT INFORMATION FORM

The patient’s overall health as well and any medications which he/she takes could have important interactions with the dental care he/she receives. Please answer each of the following questions completely.

Physician’s Name: __________________________ Phone: __________________________

Physician’s Address: __________________________ City: __________ State: __________ Zip Code: __________

Has the patient had difficulty with previous medical or dental/orthodontic visits? □ Yes □ No

Have you even been hospitalized or had a major operation? □ Yes □ No

Have you ever had a serious head or neck injury? □ Yes □ No

Are you taking any medications, pills, or drugs? □ Yes □ No

Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No

Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? □ Yes □ No

Are you on a special diet? □ Yes □ No

Do you use tobacco? □ Yes □ No

Women: Are You...

□ Pregnant/Trying to get pregnant? □ Nursing? □ Taking Oral Contraceptives?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic

□ Metal □ Local Anesthetics

□ Local Anesthetics

□ Sulfa Drugs

Are you on a special diet? □ Yes □ No

Doctor's Name: __________________________ Phone: __________________________

Physician’s Address: __________________________________________ City: __________ State: __________ Zip Code: __________

Physician’s Name: __________________________ Phone: __________________________

Physician’s Address: __________________________________________ City: __________ State: __________ Zip Code: __________

Patient’s Habits

How often does the patient brush? ___________ How often does the patient floss? ___________

Date of last dental exam: __________________________ Dentist: __________________________ Phone: __________________________

Does the patient: □ Yes □ No □ Yes □ No

Suck thumb/finger

Sucks/ bite lip

Bite/chew nails

Grind teeth

Authorization and Release

I understand that providing incorrect information can be dangerous to my child health. To the best of my knowledge the questions on this form have been accurately answered. I understand that I must inform Jamboree Dentistry of any changes in my child medical status. I authorize the dentist/orthodontist to release any information, including the diagnosis and the records of any treatment or examination given to my child to a third party payers and/ or other health practitioners. I authorize my insurance company to pay directly to Jamboree Dentistry insurance benefits otherwise payable to me. I understand if my insurance carrier may pay less than the actual bill for my services I may be responsible for any unpaid balance.

Date: __________________________

Signature of patient or guardian
TREATMENT ROOM OFFICE POLICIES

Attention Parent & Guardian

For privacy reasons, we enforce siblings, and friends to wait in the main lobby or movie theater room during treatment time. If you have any questions or concerns about your child’s treatment, please inform the front desk staff and have a seat and we will have one of our staff call you when we are ready to discuss treatment questions or concerns.

Parents/guardians are allowed to be with their children throughout the appointment at the discretion of the doctors.

As surgical procedures require a sterilized environment parents are allowed in the treatment room prior to and immediately after the procedure only.

Please direct any question and concerns about our office policy to our Office Manager.

Thank you for cooperation

Jamboree Dentistry

I acknowledge that I have received a copy of the treatment room office policies.

Patient/Parent Name: __________________________ Date: ____________________
I, ______________________________ have received a copy of this office’s Notice of Privacy Practices.

____________________________________________
Please Print Full Name

____________________________________________  _________________
Signature                                      Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barrier prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify)

__________________________________________________________________________

__________________________________________________________________________
Social Media Consent Form/Photo Release

Jamboree Dentistry on occasion takes photos and videos of patients to be used in the office, on the Jamboree Dentistry website, Facebook, news print and related publications. This list is not inclusive but serves to demonstrate situations in which patients may be photographed or filmed.

I consent that Jamboree Dentistry may use photographs or videos of my child, taken with my consent, for the above mentioned purposes. I understand that these images and/or videos will not be used for any other commercial purposes and only First names will used when referring to the child in any platform.

_____ I give permission to display my child’s photo (s) or video (s) in association with Jamboree Dentistry events, functions, publications.

_____ I request that my photo or video NOT be displayed in association with Jamboree Dentistry events, functions, publications.

Patients(s) Full Name:

1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________
6. __________________________

I, the undersigned, am parent and /or legal guardian of the patient noted on this document, and hereby fully release and discharge with Jamboree Dentistry, its owner and employees from any and all liability arising out of in connection with the above described independent activity and all liabilities associated with any and all claims related to such activity that may be filed on behalf of or for the above-named minor.

____________________________________
Parent/Guardian Name (Please Print)

____________________________________
Parent/Guardian Signature  Date: __________________________