BACK BAY
FAMILY DENTISTRY

**Jeremy W. Parker, DMD, FAGD**

4299 Popps Ferry Road
D'Iberville, MS 39540
*www.backbayfamilydentistry.com*
*P: 228-392-0509 • F: 228-392-8709*

## Patient Information

**Patient Name:** _____ **Date:** _____
**Last** **First** **MI** **(Preferred Name)**

**Gender:** _____ **Family Status:** Single, Married, Student (Child), Widowed, Other **Date of Birth:** _____

**Social Security #:** _____ **Driver's License:** _____ **State:** _____

**Phone (Home):** _____ **(Work):** _____ **Cell:** _____

**Address:** _____
**Street** **Apartment #**

_____
**City** **State** **Zip Code**

**Email Address:** _____

**Emergency Contact person:** _____ **Relationship:** _____ **Phone #:** _____

## Health Information

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer_____
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Dizziness or Fainting
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valves
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous/Anxious
- ☐ Neurological Disorder
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Acid Reflux/GERD
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ **Penicillin Allergy**
- ☐ **Codeine Allergy**
- ☐ **Latex Sensitivity**
- ☐ Cold Sores/Fever Blisters
- ☐ Mental/Psychiatric/ Psychological Care
- ☐ Thyroid Disease

Additional Allergies:
_____

☐ Other: _____

☐ **TOBACCO USE**
_____

**Women:** Are you: **Pregnant?** Yes, ____ months No **Nursing?** Yes No **Taking birth control pills?** Yes No

- Are you currently taking any **prescription** medications? ☐ Yes ☐ No
  If yes, please list: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Previous Dentist Name: _____Address: _____
- Date of Last Dental Visit: _____ Last Dental Cleaning: _____ Last Full Mouth X-rays: _____

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

_____ **Date:** _____
**Signature of patient, parent or guardian**

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## Referral Information

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

Consent

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Driver's License #: _____ Issuing State: ____ Birth Date: _____

Phone (Home): _____ (Work): _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____ Years employed? _____

Address: _____
Street City, State Zip Code Phone

## Dental Benefits Information

**Primary**

Insurance Company Name: _____ Insurance Phone #: _____
Subscriber Name: _____ Relationship to Patient: _____
Group #: _____ Cardholders's SSN: _____ Birth Date: _____
Subscriber ID #: _____

**Secondary**

Insurance Company Name: _____ Insurance Phone #: _____
Subscriber Name: _____ Relationship to Patient: _____
Group #: _____ Cardholders's SSN: _____ Birth Date: _____
Subscriber ID #: _____

## Consent for Services

I hereby authorize the doctors or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctors to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctors to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, unless other arrangements have been made in advance. In the event payments are not received by the agreed upon dates, I understand that a 5% finance charge (21% APR) may be added to my account. I understand that if my account is not paid, I would be turned over to a collection agency and /or attorney and I would be responsible for any collection fees (40% of unpaid balance), interest at the legal rate and responsible attorney fees. I hereby authorize Back Bay Family Dentistry, along with any billing services, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home or work phone using live calls, automatic telephone dialing systems and/or other computer assisted technology.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

_____ **Date**: _____ Relationship to Patient: _____
**Signature of patient, parent or guardian**

_____ **Date**: _____ Relationship to Patient: _____
**Signature of guarantor of payment/responsible party**

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## Informed Consent Form For General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

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 to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medications, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with Back Bay Family Dentistry for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Back Bay Family Dentistry, I, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Back Bay Family Dentistry.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness (es) who practice primarily in the same specialty as Back Bay Family Dentistry. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the Academy of General Dentistry. In further consideration for this, Back Bay Family Dentistry agrees to the same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this agreement. Such breach may result in irreparable harm to Doctor's reputation and business. Both Back Bay Family Dentistry and I agree in the event of a breach to allow specific performance and/or injunctive relief.

As with all healthcare treatment, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.
I understand that during the course of treatment, unforeseen circumstances and/or conditions may necessitate additional or different procedures from what was originally discussed. I, therefore, authorize and request the performance of any changes and/or additional procedures that are deemed necessary or desirable to my oral health and well-being in the professional judgement of the dentist.

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Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

- Pain, swelling, and discomfort after treatment
- Infection in need of medication, follow-up procedure or other treatment.
- Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste
- Damage to adjacent teeth, restorations or gums
- Possible deterioration of your condition which may result in tooth loss
- The need for replacement of restorations, implants or other appliances in the future
- An altered bite in need of adjustment
- Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
- A root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
- Jaw fracture
- If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
- Allergic reaction to anesthetic or medication
- Need for follow-up treatment, including surgery

The form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

**Print Patient Name** **Date**

**Patient Signature (Legal Guardian)**



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# Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing Back Bay Family Dentistry for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

Our fees are based on the quality materials we use as well as the time, effort, and skill required in performing your needed treatment. We will be sensitive to your financial circumstances and do everything possible to help you achieve optimal oral health. Ultimately, however, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your clear understanding of our financial policy is important to our professional relationship. In an effort to increase our office efficiency and keep healthcare costs down while maintaining the highest level of professional care, we have established the following office policies:

- We make a conscious effort to stay on time. Please arrive **15 minutes early** for your appointment so that the time of other patients is NOT affected. Failure to do so may result in rescheduling of your appointment. **All paperwork and consents for treatment must be signed prior to your appointment.**

- **Full (*estimated*) patient portion** is due and will be collected at the time services are rendered unless prior arrangements have been made. We accept cash and all major credit cards. Care Credit Applications must be approved and processed prior to treatment. A fee of $40.00 will be charged to accounts for each returned check.

- **A 50% non-refundable deposit is required for ALL procedures before the appointment can be scheduled and will be applied towards your appointment balance.** The remaining 50% patient balance of the treatment is due and will be collected at the time services are rendered.

- We ask for at least a one-week notice if you are unable to keep your scheduled appointment. Patients who fail to show for scheduled appointments or do not provide 48 hours' notice prior to the appointment time will be charged a no-show/cancellation fee. ($50.00 for every hour of allotted time on the hygienist's schedule and $100.00 for every hour allotted time on the doctor's schedule.) In the event of an actual emergency in which proper notice could not be given, consideration will be given, and a one-time exception may be granted at the discretion of the practice.

- I agree, in order for us to service your account or to collect monies you may owe, Back Bay Family Dentistry and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use.

- I authorize the release of any information pertinent to my treatment to my insurance company, dentist or dental specialist, physician, etc.

- I understand, that I am fully responsible for all fees incurred and account balances, regardless of my insurance benefits. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of constitution of the State of Mississippi and any other state.

**I have read, understand, and agree to the disclosure and agree that Back Bay Family Dentistry, its employees and/or agents may contact me as described above. In the event of default, I agree to pay all costs of collection as well as court costs and reasonable attorney's fees in the event legal action is taken.**

**X_____**

**Signature of Patient (or parent, if minor) Date**

(*If you are signing for a patient or minor, you are accepting financial responsibility for any services that are rendered on their behalf. *)

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# Credit Card Authorization

Back Bay Family Dentistry offers a Credit Card on File program as a convenient method of paying for treatment rendered. This includes, but is not limited to: deductibles, co-pay or co-insurance, pre-payments, payments, and/or remaining balances. The credit card information is kept confidential and secure. We follow and uphold the security requirements mandated by the Payment Card Industry (PCI) Data Security Standards (DSS) and abide by HIPAA Compliance to protect patient privacy.

I (we) understand, that I am fully responsible for all fees incurred and account balances, regardless of my insurance benefits. I (we), the undersigned, authorize and request that Back Bay Family Dentistry charge the card provided for any and all balances due. This authorization relates to all charges, including those not covered by my insurance company, for any services provided to me by Back Bay Family Dentistry. This authorization will remain in effect until I provide written notice of cancellation to the practice.

**Visa** **Mastercard** **Discover** **American Express**

**Account number: _____**

**Expiration Date: _____** **CVS Code: _____**

**Name as it appears on the card (please print) _____**

**Signature: _____** **Date: _____**

**Please note**:

- A receipt will be kept in your chart, and you can request a copy at any time
- We will NOT call you prior to charging your card, so consider this if you give us your debit card number. You may incur overdraft charges at your bank.
- If payment in not received after the first statement is issued, the account is subject to an **additional $5.00 fee** added on each statement that is required to be sent until the balance is paid in full. If you do **not** wish to receive statements in the mail, you can fill out and sign our credit card authorization to ensure that the balance will be paid in a timely manner and avoid any additional statement charges.

**No Show/Cancellation Policy**

Our practice is dedicated to quality care and exceptional service. Our doctor and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling conflicts for our team as well as other patients. In order to preserve fees, our office must maintain a predictable and efficient schedule.

Back Bay Family Dentistry request a one-week cancellation notice for all scheduled appointments. If proper notice is **NOT** received a minimum of 48 hours prior to your scheduled appointment, a fee of **$50.00** will be charged for every hour of allotted time cancelled on the hygienist's schedule and **$100.00** for every hour of allotted time cancelled on the doctor's schedule. This fee is not reimbursable by insurance and will be due **prior** to your next visit.

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## LIMITED DENTAL WARRANTY

Our practice is proud of the dentistry that we provide for you and your family. Our goal is to not just correct any dental problems you may have, but to show you how to prevent dental disease in the future to save you time and unnecessary expense. The long-term success of the dental treatment we provide for you depends upon your continuing home care of your teeth and gums, regular professional exams, cleanings and fluoride treatments. The products recommended by us for you and the frequency of those professional recare visits depends on your individual condition-and is professionally diagnosed. Those visits may be every 2, 3, 4, or even 6 months apart depending on your oral health. With that in mind we offer the following limited dental warranties:

### DENTAL SEALANTS

Sealants are plastic coatings placed on the chewing surfaces of the teeth to prevent decay in the pits and grooves of the teeth. These are the most common areas to get cavities. Floss and the use of fluoride will help prevent decay between teeth. We will repair or replace sealants for a period of 1 year after placement. If decay is present on the chewing surface, the replacement filling will be done at no charge. **You must keep the prescribed regular recall appointments or this warranty is null and void (minimum every 6 months).**

### COMPOSITE (tooth colored) FILLINGS

If a composite restoration is the recommended treatment of choice, we will replace or repair it in the event of failure for a period of 1 year. If the tooth breaks and requires a crown we will credit the cost of the filling towards the crown or onlay. **You must keep the prescribed regular recall appointments or this warranty is null and void (minimum every 6 months).**

### ROOT CANALS

Root canal treatment is about 96% successful. They do occasionally fail. If you lose your tooth within 1 year due to failure of the root canal, we will refund the root canal fee, or apply it as a credit towards a replacement tooth. **You must keep the prescribed regular recall appointments or this warranty is null and void (minimum every 6 months).**

### CROWNS, BRIDGES, AND PORCELAIN VENEERS

We will warranty these most comprehensive procedures for a full 3 years. We will replace or repair them at no charge during this 3-year period if they break or decay with normal use. (This does not include accidents that could also break normal healthy teeth.) **You must keep the prescribed regular recall appointments or this warranty is null and void (minimum every 6 months).**

**NOTE: FAILURE TO HAVE REGULAR CLEAINGS & X-RAY VISITS WITH OUR OFFICE AS DIAGNOSED VOIDS ALL WARRANTIES**. Help us to help you maintain your teeth for a lifetime.

_____

**Print Patient Name** **Date**

_____

**Patient Signature**

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____have received a copy of Back Bay Family Dentistry's office notice of Privacy Practices.

| Release of Information | Relationship | Contact# |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I understand that electronic mail (e-mail) and/or text message (SMS) are not a secure means of communication. I understand that the provider may decline to communicate via e-mail or text message depending on the nature of the medical information. I hereby give permission to Back Bay Family Dentistry (BBFD) to use electronic mail (e-mail) and text message as a means of communication regarding my care and scheduled appointments (reminders). I understand that my message and data rates may apply. I further understand that I may withdraw this authorization at any time by notifying BBFD in writing.

_____
**Print Name**

_____
**Signature**

_____
**Date**

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