



Welcome!

We are delighted that you have chosen Joiner Family Dentistry for your dental needs.

What a difference when you walk through the front door.....you will find a comfortable reception area, enjoyable atmosphere, as well as friendly staff members attentive to each individual's needs and well-being. State of the art equipment, sterilization, and techniques provide service of the highest quality. So, please let us know of anything to make your visit as pleasant an experience as possible.

Enclosed are the New Patient Information, Medical / Dental History, Records Transfer and HIPAA release Forms . Please return the forms to our office as soon as possible. This will allow us to be fully prepared to provide you highest quality dentistry at your appointment.

Your appointment time is especially reserved for you and typically will last a little over an hour. If you have dental insurance, please bring your card with you. For your convenience we accept cash, check, credit cards, and third party financing. We do require payment the day of service including any co-pays or deductibles estimated to not be covered by insurance.

We are easy to locate at 123 Albany Ave. SE across from the Orange City Public Library. We are located in the Dutch Plaza which has plenty of accessible parking in the front, side and back of the building. You will find a map on the new patient page of www.joinerdentistry.com.

Again, we are pleased to have you as a new patient and look forward to meeting you. If you have any questions or need help with anything, please call (712) 737-3521 or email dental@joinerdentistry.com.

Sincerely,

Dr. Joiner & Staff

Preferred Name _____

CONFIDENTIAL PATIENT INFORMATION

TODAYS DATE: ____/____/____

NAME Last _____ First _____ Middle _____ SEX: M F

STREET ADDRESS _____ City _____ State _____ Zip _____

MAILING ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____ - _____ - _____ BIRTHDATE ____/____/____ AGE ____ DRIVERS LICENSE # _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____ MARRIED? YES NO

EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT (circle one) Home Phone Cell Phone Work Phone Email Text Messages Other _____

RESPONSIBLE PARTY INFORMATION

IF SAME AS PATIENT INFORMATION—SKIP THIS SECTION RELATIONSHIP TO PATIENT _____

NAME Last _____ First _____ Middle _____ SEX: M F

ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____ - _____ - _____ BIRTHDATE ____/____/____ AGE ____ DRIVERS LICENSE # _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____ MARRIED? YES NO

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)	SECONDARY DENTAL INSURANCE INFORMATION
INSURED'S NAME _____	INSURED'S NAME _____
INSURANCE COMPANY _____	INSURANCE COMPANY _____
INS. CO. ADDRESS _____	INS. CO. ADDRESS _____
CITY _____ ST _____ ZIP _____	CITY _____ ST _____ ZIP _____
INSURED'S EMPLOYER _____	INSURED'S EMPLOYER _____
INSURED'S BIRTHDATE ____/____/____	INSURED'S BIRTHDATE ____/____/____
INSURED'S SSN# ____/____/____ ID# _____	INSURED'S SSN# ____/____/____ ID# _____
GROUP # _____ LOCAL # _____	GROUP # _____ LOCAL # _____
-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-	-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE # (____) _____ - _____ WORK # (____) _____ - _____ CELL # (____) _____ - _____

CONSENT

The undersigned hereby attests that the above information is complete and accurate. I authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a rebilling fee will be added to any overdue balance. I also acknowledge that I have been offered a copy of the offices Notice of Privacy Practices as required by law. I also understand that I can refuse parts of this consent by crossing out those sections that I disagree with but by so doing the Doctor may refuse treatment.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____/____/____

CONFIDENTIAL PATIENT INFORMATION PAGE 2

Health and Dental History

Name _____

DENTAL HISTORY (CIRCLE YES OR NO AS NEEDED)	MEDICAL HISTORY (CIRCLE YES OR NO AS NEEDED)
Are you having PROBLEMS or DISCOMFORT now? Yes No	Do you have any current HEALTH PROBLEMS? Yes No
PLEASE DESCRIBE	Are you under a PHYSICIAN'S CARE? Yes No
	PLEASE DESCRIBE
Do you wear DENTURES? Yes No	What MEDICATIONS do you take and for what REASON do you take it:
Have you had any PERIODONTAL (GUM) Treatment? Yes No	
Do your gums BLEED or feel TENDER or IRRITATED? Yes No	
Are your teeth SENSITIVE to hot, cold, sweets or pressure? Yes No	
Are you aware of GRINDING or CLENCHING your teeth? Yes No	
Have you worn BRACES? (ORTHODONTICS) Yes No	
If yes, do you wear a RETAINER? Yes No	Are you aware of any medications you are ALLERGIC to? Yes No
Would you like to change the APPEARANCE of your SMILE? Yes No	PLEASE LIST
PLEASE DESCRIBE	
	Are you allergic to LATEX? Yes No
Are you APPREHENSIVE about dental treatment? Yes No	Are you PREGNANT? Yes No
Have you ever been or interested in being SEDATED for dental treatment with drugs or NITROUS OXIDE (LAUGHING GAS)? Yes No	Do you SMOKE? Yes No
When was your last visit to a dentist and for what reason?	Please circle any of the following conditions you have had or presently have:
	Prosthetic (Hip, Knee, etc.) Heart Disease or Attack Heart Murmur
	Mitral Valve Prolapse Rheumatic Fever Stroke
	Diabetes Kidney Problems Liver Disease
	High/Low Blood Pressure Hepatitis Tuberculosis (TB)
	AIDS or HIV Positive Cancer/Chemotherapy Asthma
	Pacemaker Drug/Alcohol Addiction
When was your last exam and cleaning?	Other: PLEASE LIST BELOW
Please describe any other information you feel we should know:	
Have you been told to take an ANTIBIOTIC PREMEDICATION before any dental treatment by a dentist or physician? Yes No	Do you take any herbal supplements? If yes please list below
If yes, for what reason?	

Family Physician _____ City/State of Clinic _____

The undersigned hereby attests that the above information is complete and accurate.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____ / ____ / _____

Privacy Policy Acknowledgement Form

The form below is required to be signed by the federal government. The privacy policy that you acknowledge is available to be read at:

<http://www.joinerdentistry.com/IMAGES/HIPAANotice.pdf>

The notification is also available in our office. If you have any questions, do not hesitate to ask.

<p>Joiner Family Dentistry</p> <p>ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES</p> <p>**You May Refuse to Sign This Acknowledgement**</p> <p>I, _____, have offered a copy of this office's Notice of Privacy Practices.</p> <p style="text-align: center;">{Please Print Name}</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">{Signature}</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">{Date}</p> <hr/> <p style="text-align: center;">For Office Use Only</p> <hr/> <p>We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:</p> <p>Individual refused to sign</p> <p>Communications barriers prohibited obtaining the acknowledgement</p> <p>An emergency situation prevented us from obtaining acknowledgement</p> <p>Other (Please Specify) _____</p>

Dental Records Release Form

Patient Name to transfer: _____

Date of Birth: _____

Phone number: _____

Other family members to transfer: _____

Previous Dentist or Practice Name: _____

Address: _____

City/St/Zip : _____

Phone number: _____

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Joiner Family Dentistry.

I hereby give you permission to release any and all of my dental records to Dr. Joiner.

Patient Signature (parent if a minor)

Date

If records are digital, please email to:

dental@joinerdentistry.com

Or mail to:

Joiner Family Dentistry
123 Albany Avenue SE
PO Box 198
Orange City, IA 51041