PARKER DENTAL
J. WESLEY PARKER, II PLLC
27 OFFICE PARK DR.
JACKSONVILLE, NC 28546
(910)577-7775

Today's Date:_____

Patient Information Sheet

Patient Name:Last_____First:_____Middle:_____
DOB:_____Age:____ SS#:_____ Sex(M/F)____
Home Address:_____City:_____State:_____Zip:_____
Home#_____Cell#_____Work#_____
Correspondence by email check(Yes or No) ☐ Yes ☐ No Email Address: _____
DL#_____Marital Status:_____
Employer:_____ Occupation:_____
Spouse Name: _____ SS# _____
Mother / Father Name (if patient is a minor) _____
To whom shall statements be sent if other than patient?_____
Address if different than patient:_____

Contact Person In Case Of Emergency:
Name:_____Phone#_____Relationship_____

Dental Insurance Information

Name of Insured: _____ Relationship_____
DOB _____SS#_____
Employer:_____ Primary Dental Insurance:_____
Member ID#_____ Group#_____ Rank:_____
If patient is a full time college student, name of the college:_____

Secondary Dental Insurance
Name of Insured: _____ Relationship_____
DOB _____SS#_____
Employer:_____ Secondary Dental Insurance:_____
Member ID#_____ Group#_____ Rank:_____

I hereby authorize my insurance carrier to pay benefits directly to J.Wesley Parker, DDS. I understand I am responsible to pay for services not covered by my insurance. I also authorize the release of any information regarding a claim to my insurance company for procedures performed by Dr. Parker, DDS. I also understand I am responsible to pay for expenses that may accrue do to collection and or interest charges.

Signature_____ Date:_____

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Financial and Office Policies

Thank you for understanding that we file all dental insurance as a courtesy to our patients, however, we are not in network with all insurance companies, therefore, we may not have a contract with your specific insurance company. We are not responsible for how your insurance company handles their claims or for what benefits they pay on a claim. We can provide assistance with **ESTIMATING** your portion of the cost of treatment. However, we cannot guarantee what your insurance company will or will not cover in regards to each filed claim.

If we have received all your insurance on the day of your appointment, we will be happy to file the claim for you. **Please become familiar with your insurance benefits, as on the date of service we will collect your estimated portion.** If we are unable to verify insurance benefits due to insufficient or inaccurate information, you will be responsible for paying the full amount of your visit. By law, your insurance company is required to pay claims within 30 days of receipt. We file most insurance electronically. That means your insurance company should receive each claim within several days of your treatment. You will be responsible for any balance remaining on your account after 30 days, whether insurance has paid or not. We will be glad to send you a refund once your insurance has paid us if there is any over payment.

Please carefully read the following information that will help you understand some general guidelines about dental insurance benefits.

- No insurance pays 100% of all procedures – many patients assume their insurance pays 90% - 100% of all dental fees. Most plans only pay between 50% - 80% of the average total fee. Some pay more, some pay less.
- The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.
- Sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee (UCR) used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider "allowable".
- Our dental material of choice for "fillings" is a white filling, also known as composite resin. Some insurance companies do not pay for a white filling (composite resin) at the same level as a silver filling (amalgam). The difference between the two fees will be your responsibility.
- Some dental insurers will not reimburse the provider (Dr. Parker) at the same level as a silver filling (amalgam). The difference between the two fees will be your responsibility.

- Some dental insurers will not reimburse the provider directly for treatment but rather the subscriber. In this case, the patient is responsible for paying the full amount for treatment rendered on the day of service.

Financial Options

Dental treatment is an excellent investment in an individual's well-being; financial considerations should not be an obstacle to obtain health. Being sensitive to the fact that patients have different needs in fulfilling their financial obligations, we are providing that following payment option.

Cash or Check – 5% courtesy discount when paid in full at the time of service, this is for patients who do not have insurance coverage, only.

Credit Card or Debit Cards – Visa, MasterCard, American Express, or Discover

Care Credit – This is a line of credit, subject to credit approval. If application is denied, another form of payment listed above is required. We can assist with the application process.

Office Policies

- We ask that you arrive 10 minutes early for your appointment to ensure you have time to fill out updated paperwork that may be needed. At minimum please arrive on time to your appointments to ensure you get the full treatment you were scheduled for. Arriving 15 minutes late or more will result in us rescheduling your appointment to a time that will better suit your schedule and ours.
- It is the responsibility of the patient to provide our office with a current phone number and address to confirm appointments. If we are unable to contact you 24 hrs. Prior to your scheduled appointment time, we reserve the right to remove your appointment from the schedule until we can contact you to confirm.
- Please give a minimum 24 hours notice if you are unable to keep your appointment. Short cancellations severely limit our ability to provide quality services efficiently because of losses incurred due to last minute cancellations.
- After 3 "No Show" appointments (where 24 hours' notice has not been given to cancel), we reserve the right to dismiss you from our practice due to non-compliance.
- If you're a new patient to our practice and reschedule and / or cancel your initial appointment more than 2 times, we will no longer be able to schedule you. Please be sure to arrive at least 15 minutes early to get your paperwork completed before your appointment.

If you are medicated with a drug for a dental procedure that impairs you mentally or physically you MUST have a driver bring you to your appointment and take you home. If you are to pay, you must pay prior to your appointment before you have taken any medication.

I have read the financial options and Office policies and have provided the correct insurance information, if any. I understand that, regardless of the insurance coverage I may have, I am fully responsible for the payment of my account in a timely fashion.

Signature _____ Date _____

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General Dental Informed Consent

Dr. Parker would like all of his patients to have knowledge of risks and benefits of dental procedures. We ask that your review the procedures listed and feel free to ask any questions. A treatment plan for all restorative work, which includes **ESTIMATED** fees and treatment specific authorization, will be presented to you for your review and signature at the time treatment is recommended.

1. **Drugs and Medications**: Antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Risk of local anesthesia may include temporary or permanent numbness or bruising.
2. **Changes in Treatment**: During treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
3. **Removal of Teeth**: Alternatives will be explained to you (root canal therapy, crowns, and periodontal surgery, etc.). The removal of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Some of the risks re pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. Further treatment by a specialist or even hospitalization if complications arise during or following treatment would be your responsibility.
4. **Crown and Bridges**: Sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. You may wear temporary crowns, which may come off easily. You will need to be careful to ensure that they are kept on until the crown, or bridge (including shape, fit, size, or color) must be done at the preparation appointment.
5. **Partials and Dentures**: They are artificial, constructed of plastic, metal and/or porcelain. The problem of wearing these appliances, including looseness, soreness, and possible breakage. Most partials and dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is no included in the initial fee.
6. **Periodontal Loss (Tissues & Bone)**: This is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth. Alternative treatment will be explained to you (gum surgery, replacements, and/or extractions). Any dental procedure may have a future adverse effect on your periodontal conditions.
7. **Implant and Implant Crown**: They are a permanent alternative to bridges, partial or dentures. This process involves the participation of an oral surgeon. Fees for his/her services are separate from our service fees. This process involves several steps and could last from 2-6 months before complete (depending on healing time needed). As with crowns, color may not match perfectly with natural teeth.
8. **Sealants**: There is no guarantee that a sealant will prevent all cavities. They do, however, form a hard shield that keeps food and bacteria from getting into tiny grooves and causing decay along the chewing surfaces of the back teeth. Occasionally sealants need to be replaced, since they do not last a lifetime. We

do, however, warranty our sealants for 2 years as long as the patient is seen twice a year however, warranty our sealants for 2 years as long as the patient is seen twice a year for prophylaxis visits. Sealants can be done at any age as long as the teeth are free of decay and fillings. The doctor will determine the best time to have them done.

9. **Sedative Fillings**: Sedative fillings are temporary. They are placed if near caries exposure of the nerve is suspected. If the tooth becomes symptomatic after 4-6 weeks, it's likely the tooth will need a root canal or it may need to be extracted. If the tooth is asymptomatic after 4-6 weeks, than the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and will enable the Doctor to remove the decay and restore the tooth.

Treatment Risk: I understand that any time a restoration is performed there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, hot sensitivity, biting sensitivity, abscess, and pulp necrosis. There is a risk when using anesthetic of prolonged numbness or allergic reactions to anesthetic, stroke, heart attack, blood clots, and nausea.

Most of the symptoms usually resolve as the verve heals. "Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal.

I have carefully read above conformed consent and fully understand all risks as it relates to my case.

Patient Signature: _____

Date: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows Parker Dental to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

(Name of Practice)

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Main Contact Number:** (___) _____
mm/dd/yyyy ☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE

☐ Main Contact Number Above

☐ Other: (___) _____
☐ Home ☐ Cell* ☐ Work

DETAILED MESSAGES PERMITTED

☐ text (SMS)* ☐ voicemail/answering machine ☐ None

☐ text (SMS)* ☐ voicemail/answering machine ☐ None

EMAIL*

☐ _____

☐ All information from this practice
☐ Appointment information only (request/confirm/cancel)
☐ Data breach notifications
☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____
First and Last Name

Phone: (___) _____

Email:* _____

Other: _____
First and Last Name

Phone: (___) _____

Email:* _____

Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

Signature: _____