DR. RICHARD H JENSON D.D.S

FAMILY DENTISTRY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health care.

PATIENT INFORMATION

Date ______ Home Phone ______ Cell Phone ______

Name ______ LAST ______ FIRST ______ MIDDLE INITIAL ______ SS/HIC/Patient ID # ______

Address ______ Email ______

City ______ State ______ Zip ______ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Sex: ☐ M ☐ F Age ______ Birthdate ______ ☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______ Patient Employer/School ______

Employer/School Address ______ Employer/School Phone ______

Whom may we thank for referring you? ______

In case of emergency who should be notified? ______ Phone ( ) ______

PRIMARY INSURANCE

Person Responsible for Account: ______ LAST NAME ______ FIRST NAME ______ MIDDLE INITIAL

Relation to Patient ______ Birthdate ______ SS/ID # ______

Address (if different from patient's) ______ Phone ( ) ______

City ______ State ______ Zip ______

Person Responsible Employed By ______ Occupation ______

Business Address ______ Business Phone ( ) ______

Insurance Company ______

Contract # ______ Group# ______ Subscriber# ______

Names of other dependents covered under this plan ______

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______ Relation to Patient ______ Birthdate ______

Address (if different from patient's) ______ Phone ( ) ______

City ______ State ______ Zip ______

Subscriber Employed By ______ Business Phone ( ) ______

Insurance Company ______ Social Security # ______

Contract # ______ Group# ______ Subscriber# ______

Names of other dependents covered under this plan ______

Please Complete Both Sides

DENTAL HISTORY

Reason for today's visit ______ Date of last dental care ______

Former Dentist ______ Date of last dental X-rays ______

Address ______ City ______ State ______ Zip ______

Check (?) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______ How often do you brush? ______

MEDICAL HISTORY

Physician's Name ______ Date of last visit ______

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control bills? ☐ Yes ☐ No

Check (?) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking: ______ Allergies: ______

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with ______ (NAME OF INSURANCE COMPANY(IES)) and assign directly to Dr. Richard H. Jenson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______ SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTITIVE ______ DATE

______ PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTITIVE ______ RELATIONSHIP TO PATIENT

Payment is due in full at time of treatment unless prior arrangements have been approved.

DENTAL HEALTH INFORMATION

Thank you for providing us with important information that will help us serve you better.

	Yes	No
Does dental treatment make you nervous?	☐	☐
Do you think your dental health effects your overall heath?	☐	☐
Do you think it is important to have your teeth cleaned at least every six months?	☐	☐

On a scale of 1 to 10 with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

Have you ever suffered from, or been told you may have any of the following?

	Yes	No
Gum disease	☐	☐
Bruxism or Grinding	☐	☐
Jaw pain or TMJ	☐	☐
Dental pain	☐	☐
Bad breath	☐	☐
Headaches or Migraines	☐	☐

	Yes	No
Is the brightness of your teeth important to you?	☐	☐
Do you smoke or use tobacco in any form?	☐	☐
Do you drink coffee, tea, or dark colas?	☐	☐

If I could change my smile I would make my teeth:

	Yes	No
Whiter	☐	☐
Straighter	☐	☐
Close space	☐	☐
Repair chipped teeth	☐	☐
Replace missing teeth	☐	☐
Less gum showing	☐	☐
Replace old crowns or caps that don't match	☐	☐
Replace black mercury fillings with Tooth colored restorations	☐	☐

Would you like to improve your smile? Y N How?____

____

Medical History Update

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ____

Are you taking any new medication?____ If so, what ____________________________________

__________ ____
Date Patient Signature

__________ ____
Date Patient Signature

DR. RICHARD H JENSON D.D.S

FAMILY DENTISTRY

I, _______________________ (Patient), authorize

Dr. Richard H. Jenson DDS, to take photographs, and/or videos of my face, jaw and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

-Dental Records

-Dental Research

-Dental Education including lectures, seminars, demonstrations, professional publication such as journals or books

-Marketing material, including websites and printed materials, patient education and social media

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your name used for any of the above purposes

☐ Check here if you do not want your full face shot used for any of the above purposes

Name (please print):______________________________

Signature (Patient) _______________________________

Date_____________________

For Minors:

Name of Minor (please print):________________________

Name of Parent or Legal Guardian (please print):_____________________

Signature:______________________________

Date:___________________

CONSENT TO PROCEED

I authorize Dr. Richard H. Jenson and/or such associates or assistants as slhe may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment may be required.
I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments,

drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series ofx-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensw·e safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

HIPPA- ACKNOWLEDGEMENT OF RECEIPT of privacy policy notification &
AUTHORIZATION & CONSENT FOR USE AND DISCLOSURE of Health Infonnation as it applies to treatment, payment activities, and healthcare operations.

Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collections fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

For further explanation, notify our office. We will be happy to assist you to understand what this Privacy Policy means to you.

Patient Name: ____

Signature: ______________________________ Date: _______________

Witness: ________________________________ Date: _______________