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 _____ SS/HIC/Patient ID # _____
LAST FIRST MIDDLE INITIAL

Address _____ Email _____

City _____ State _____ Zip _____ ❑ Married ❑ Widowed ❑ Single ❑ Minor

Sex: ❑ M ❑ F Age _____ Birth Date _____ ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Occupation _____ Patient Employers/School _____

Employers 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: _____

Relation to Patient _____ Birth Date _____ SS/ID # _____

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

City _____ State _____ Zip _____

Personal Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Insurance Company _____

Contact # _____ 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 _____ Birth Date _____

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 Filling
- ❑ Periodontal Treatment
- ❑ Sensitivity to Cold
- ❑ Sensitivity To Hot
- ❑ Sensitivity to Sweets
- ❑ Sensitivity When Biting
- ❑ Sores or Growth 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 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 pills? ❑ 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 _____ and assign directly to
NAME OF INSURANCE COMPANY(IES)

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 REPRESENTATIVE DATE

_____ _____
PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

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

CONSENT TO PROCEED, FINANCIAL RESPONSIBILITY/PRIVACY NOTICE ACKNOWLEDGEMENT

I authorize Dr. Richard H. Jenson and/or such associates or assistants as s/he 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 of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure 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.

I take full responsibility for payment in full and understand that if my account be turned over for collection, I agree 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%. I understand 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. I further acknowledge Jenson Dental may bill my dental benefit plan as a courtesy for me, but that does not release me of financial liability for payment of services rendered.

Jenson Dental is required by law to maintain the privacy of patient protected healthcare information, and provide patients with the their Notice of Privacy Practices detailing their legal duties and practices with respect to protected health information. I understand that if have any objections to the Notice, I may speak with the practice HIPAA Compliance Officer in person or by phone at the Jenson Dental main phone number. If I would like a copy of the Notice, I may request one.

I hereby acknowledge that I have been given access to and/or reviewed the HIPAA Notice of Privacy Practice for JENSON DENTAL.

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Signature of patient or patient's representative/parent Date