JENSEN ENDODONTICS, INC.

PATIENT REGISTRATION

Today's Date _____ **Referring Dentist**_____

PATIENT INFORMATION (CONFIDENTIAL)

First Name _____M._____ Last Name_____
Address_____
City _____ State _____Zip _____
Home Phone _____Work #_____Ext_____ Cell#_____
SEX: ___Male ___Female
MARITAL STATUS: __Married __Single __Divorced __Separated __Widowed
Birth Date _____ Age _____ SS# _____
E-mail address _____

RESPONSIBLE PARTY (if not patient)

Person's Name _____Relationship to Patient_____
Address _____ City/State_____Zip_____
Employer _____ Home Phone_____Work Phone _____
Birth Date_____ Age_____ SS#_____

-PRIMARY- DENTAL INSURANCE INFORMATION

Name of Insured _____Relationship to Patient _____
Address_____City/State_____Zip_____
Birth Date _____ **SS#** _____ **ID#**_____
Employer _____Union/Local #_____ Work Phone _____
INSURANCE COMPANY_____ **GROUP #** _____
Address _____City/State_____ Zip_____
Phone Number _____

-SECONDARY- DENTAL INSURANCE INFORMATION

Name of Insured _____Relationship to Patient _____
Address_____City/State_____Zip_____
Birth Date _____**SS#** _____ **ID#**_____
Employer _____Union/Local #_____ Work Phone _____
INSURANCE COMPANY_____ **GROUP #** _____
Address _____City/State_____ Zip_____
Phone Number _____

AUTHORIZATION and RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependants.**

X_____
Signature of patient (or parent/guardian if minor)

JENSEN ENDODONTICS, INC.

MEDICAL HISTORY

PATIENT NAME _____ **BIRTH DATE** _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No
Have you ever been hospitalized or had a major operation?	Yes No
Have you ever had a serious head or neck injury?	Yes No
Have you ever taken **Fosamax, Boniva, Actonel,** or any other medications containing **bisphosphonates**?	Yes No
Do you use controlled substances?	Yes No
Do you use tobacco?	Yes No
Are you taking any medications, pills, and drugs?	Yes No **LIST THEM BELOW**

LIST ALL MEDICATIONS _____

WOMEN: Pregnant/Trying to get pregnant? _____ Nursing? _____ Taking Oral Contraceptives? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? PLEASE CIRCLE

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

OTHER ALLERGIES PLEASE LIST: _____

Do you have, or have you had, any of the following? **PLEASE CIRCLE**

AIDS/HIV Positive	Easily Winded	Leukemia
Alzheimer's Disease	Epilepsy or Seizures	Liver Disease
Anaphylaxis	Excessive Bleeding	Pain in Jaw Joints
Angina	Convulsions	Low Blood Pressure
Artificial Heart Valve	Fainting/Dizziness	Mitral Valve Prolapse
Artificial Joint	Hay Fever	Osteoporosis
Asthma	Heart Attack/Failure	Psychiatric Care
Breathing Problems	Emphysema	Radiation Treatment
Bruise Easily	Heart Trouble Disease	Rheumatic Fever
Cancer	Heart Murmur	Sickle Cell Disease
Chemotherapy	Heart Pacemaker	Sinus Trouble
Chest Pains	Hemophilia	Stomach/Intestinal
Congenital Heart Disorder	Hepatitis B or C	Stroke
Diabetes	High Blood Pressure	Tuberculosis
Drug Addiction	Hives or Rash	Tumors/Growths
		Ulcers

Have you ever had any serious illness not listed above: **Yes** **No** _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN **DATE**

Jensen Endodontics, Inc.

FINANCIAL POLICY

05/14/2019

To help maintain our reasonable fees, and to minimize our ever increasing operating expenses we request the following payment methods.

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT.

We accept **MASTERCARD, VISA, AMERICAN EXPRESS, and DISCOVER**. We also accept **CARECREDIT.**

As a courtesy to our patients, we will process **insurance** claims for services rendered. **HOWEVER, it should be understood that charges incurred for services rendered remain the responsibility of the patient or responsible party at all times. You should know what coverage you have under your plan and exactly what your benefit coverage includes under your plan. Any dispute arising over insurance coverage, non-allowable expenses, etc., are between you and your insurance carrier and will not interfere with our collection process.**

Billing statements are sent out monthly. Unpaid balances over 90 days may be turned over to collections

SURGICAL PATIENTS: If a biopsy is performed, you will be billed directly from Ohio State Laboratories. Ohio State Labs will assist you with submitting to your Medical Insurance.

I have read and understand the above information.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental Care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.**

X_____ _____

Patient Signature **Date**

X_____

Guardian/Responsible Party Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

***posted in our office or available upon request**

_____ **X**_____ _____

Please Print Name **Signature** **Date**

Information Sharing: Please list any individuals we can share your personal information with other than healthcare providers.

Name:_____ **Relationship:**_____ **Phone Number**_____

Name:_____ **Relationship:**_____ **Phone Number**_____