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 2019

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.

PLEASE EXPLAIN ANY "YES" ANSWERS IN THE SECTION BELOW:

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 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, or 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
Alzheimer's Disease
Anaphylaxis
Angina
Artificial Heart Valve
Artificial Joint
Asthma
Breathing Problem
Bruise Easily
Cancer/Tumors/Growths
Chemotherapy
Chest Pains
Congenital Heart Disorder
Convulsions
Diabetes

Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Fainting/Dizziness
Hay Fever
Heart Attack/Failure
Heart Disease
Heart Murmur
Hemophilia
Hepatitis B or C
High Blood Pressure
Hives or Rash
Leukemia

Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Osteoporosis
Pacemaker
Pain in Jaw Joints
Psychiatric Care
Radiation Treatment
Rheumatic Fever
Sickle Cell Disease
Sinus Trouble
Stomach/Intestinal Disorders
Stroke/TIA
Tuberculosis
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**_______________