JENSEN ENDODONTICS, INC.
PATIENT REGISTRATION

Today's Date ________________ **Referring Dentist___________________________**

PATIENT INFORMATION (CONFIDENTIAL)

First Name _____________________M._________ Last Name_________________________________
Address____
City ______________________ State ___________________ Zip ________________________
Home Phone _________________ Cell Phone __________________
Accept Voicemails/Messages Regarding Appointment and/or Financial Information? ___ Yes ___ No
Accept Texts Regarding Appointment and/or Financial Information? ____Yes ____ No
SEX: ___Male ___Female ___Other
MARITAL STATUS: __Married __Single __Divorced __Widowed
Birth Date _________________ Age _____ SS# _______________________________________
E-mail address ____

RESPONSIBLE PARTY (if not patient)

Person's Name ____________________________________ Relationship to Patient_________________
Address __________________________________ City/State ______________ Zip _________________
Employer _________________________ Cell 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 dependents.**

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.

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

To help maintain our reasonable fees, and to minimize our 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 personal checks, cash (exact amount only) and **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 on our website 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:** _________________