Patient History

Rhonda Jensen D.D.S.
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Introductory Information

Please Answer Each Question

Name_____Date of Birth_____
Last First Middle Nickname

Residence Address_____
Street City State Zip

Employed By_____ Business Address_____

Occupation_____ Present Position_____ How Long? _____

Home Phone _____Mobile Phone_____ Email_____

Business Phone_____ Can we contact you at this number? YES or NO

Social Security Number_____-_____-_____ Drivers License Number_____

If Insured by Spouse: Spouse's Name_____

Spouse's date of birth _____ Social Security No. _____-_____-_____

Dental Insurance Carrier_____ Group No._____

Spouse Employed By_____ Address_____
Street City Zip

Business Phone_____ Can we contact you at this number? YES or NO

Person financially responsible for this account_____

Referred to this office by _____

Emergency contact _____Phone Number_____

* I understand that it is my responsibility to know my insurance benefits and the extent of coverage by my insurance company. Although this office is happy to bill insurance claims, I understand that it is my responsibility to pay for any charges not covered by my insurance company. I also understand that my estimated co-payment is due when services are rendered unless prior arrangements have been made.

* Once an appointment has been made, please remember this time is reserved for you. At least 24 Hr notice must be given if cancellation is necessary. A cancellation charge will be applied to all appointments canceled without 24 business hours notice.

I have read the above and understand that I am responsible for all charges incurred.

_____

Signature Date

Medical History

1. Are you having pain or discomfort at this time?..... YES NO
2. Do you feel very nervous about having dental treatment?..... YES NO
3. Have you ever had a bad experience in a dental office?..... YES NO
4. Have you been a patient in the hospital during the past two years?..... YES NO
5. Have you taken any medicine or drugs during the past two years?..... YES NO
6. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by Penicillin, aspirin, codeine, latex or any drugs or medications? Name_____ YES NO
7. Have you ever had any excessive bleeding requiring special treatment?..... YES NO
8. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	Hepatitis A (Infectious)
Heart Disease or Attack	Cough	Hepatitis B (serum)
Angina Pectoris	Tuberculosis (TB)	HIV
High Blood Pressure	Asthma	Yellow Jaundice
Heart Murmur	Hay Fever	Blood Transfusion
Rheumatic Fever	Sinus Trouble	Drug Addiction
Congenital Heart Lesions	Allergies or Hives	Hemophilia
Scarlet Fever	Diabetes	Venereal Disease (Syphilis, Gonorrhea)
Artificial Heart Valve	Thyroid Disease	Cold Sores
Mitrol Valve Prolapse	X-ray or Cobalt Treatment	Implant (i.e. breast, chin, etc.)
Heart Pacemaker	Chemotherapy (cancer, Leukemia)	Genital Herpes
Heart Surgery	Arthritis	Epilepsy or Seizures
Artificial Joint	Rheumatism	Fainting or Dizzy Spells
Anemia	Cortisone Medicine	Nervousness
Stroke	Glaucoma	Psychiatric Treatment
Kidney Trouble	Pain in Jaw and Joints	Sickle Cell Disease
Ulcers	AIDS	Bruise Easily
Liver Disease		

9. Have you been tested for HIV? Date _____ ..... YES NO
10. Are you aware of needing any premedication prior to dental treatment?..... YES NO
11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?..... YES NO
12. Do you snore?..... YES NO
13. Are you on a special diet?..... YES NO
14. Has your medical doctor ever said you have cancer or a tumor?..... YES NO
15. Do you have a disease, condition , or problem not listed?..... YES NO
16. WOMAN: Are you pregnant now?..... YES NO
    Are you practicing birth control?..... YES NO
    Do you anticipate becoming pregnant?..... YES NO
17. Do you smoke?..... YES NO
18. Do you drink alcoholic beverages? Daily_____Weekly_____Monthly_____None_____
19. List medications taken daily_____

_____

_____

Date Signature of patient, parent or guardian

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COMMENTS

_____

_____

_____

_____ _____

Date Reviewed By

Dental Services Financial Agreement

Dr. Rhonda Jensen's goal is to help you establish excellent oral health. She is committed to helping you determine the most appropriate treatment for your dental needs and desires. Should you have questions concerning your treatment, treatment sequence, or fees for services, **please ask** for clarification before treatment is begun.

Our financial policy is as follows:

- We accept cash, personal checks, and credit cards including MasterCard, Visa, American Express, and Discover.
- Payment is due in full at the time of service.
- Insurance – insurance is a contract between the patient, employer and the insurance company. It is not a contract between our office and your insurance company. It is important you understand your dental coverage.
- We will be happy to assist you by filing your insurance claim electronically and answering the details that the insurance company may require. We cannot be responsible for payment by the insurance company. **The responsibility for payment belongs to the patient.**
- Per your request, we will provide estimated balances between the cost of service and co-payment of your insurance. Predetermination of any benefits may be advisable if there is a question concerning coverage. Estimated coverage is **NOT A GUARANTEE** of payment or coverage.
- We will accept assignment of benefits subject to verification of insurance coverage.
- First office visits that are Emergency visits – full payment will be expected regardless of insurance.
- Extended treatment plans will be outlined so that appropriate payments may be made for each phase of treatment.

We reserve the right to accept or deny certain insurance plans at our discretion. If we accept your insurance plan, a minimum 20% co-payment is due at the time of service. If your insurance company has not paid the full balance within 45 days, you will have 15 days to pay the balance. A monthly finance charge of 10% will be added monthly to any unpaid balances after 60 days from the date of service.

Should your insurance plan be denied, full payment is expected at the time of service unless prior arrangements have been made through our office manager. A monthly finance charge of 10% percent will be added to any unpaid balances after 60 days from the date of service.

If you have a balance after insurance has paid their share, payment is due 30 days from the date of insurance payment. A monthly finance charge of 10% will be added to any unpaid balance after 60 days from the date of insurance payment.

If you do not have insurance and you are unable to pay your balance in full at the time of service, a monthly finance charge of 10% will be added to any unpaid balances after 30 days.

Please remember that you are responsible for timely payment of your account. Should it become necessary to refer your account to an agency or attorney for collection, you will also be responsible for all costs associated with the collection including attorney's fees and court costs.

I understand the above policy and agree to the terms herein.

_____ _____

Individual/Parent/Guardian/Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I acknowledge that I have received from Dr. Rhonda Jensen, the Dental Materials Fact Sheet that was updated on May 14, 2004

Patient Name

Signature of Patient, Parent, or Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the Notice of Privacy Practices from Dr. Rhonda Jensen.

Patient Name

Signature of Patient, Parent, or Guardian Date