PATIENT INFORMATION SHEET

(PLEASE PRINT CLEARLY)

Date: _____

Last Name_____ First Name_____ MI_____

What Name/Nickname Do You Use?_____ Sex (M/F)____

Marital Status (Single/Married/Divorced)_____ Date of Birth_____

Social Security No. _____ - _____ - _____ Driver License No. _____ **Copy required**

Whom May We Thank For Referring You to Our Office?_____

LOCAL ADDRESS:

Street_____ Apt. #_____

City_____ State_____ Zip_____

Home Tel. ( )_____-_____ Bus. Tel. ( ) _____-_____ Ext_____

Cell Phone_____ E-Mail_____

PERMANENT ADDRESS: (if different from above)

Street_____Apt. #_____

City_____ State_____ Zip_____

Home Tel. ( )_____-_____ Bus. Tel. (_____) _____-_____ Ext_____

IF PATIENT IS A MINOR: Father's Name_____

Mother's Name_____

EMERGENCY INFORMATION:

Person To Contact In Case of Emergency

Name_____ Phone (_____) _____

City_____ State_____ Zip_____

FINANCIAL POLICY:

Payment is expected in **full at each appointment.** We accept cash, personal checks, VISA, MasterCard and American Express. A copy of your driver's license is required for proper identification. **If you have dental insurance,** and after your insurance benefits are verified, you will be responsible for all deductibles and estimated co-payments at the time services are rendered.

Any treatment involving laboratory fees (crowns, bridge, partials, dentures, etc.) must be paid as follows: ½ of the total fee at initial treatment visit, and the remaining 1/2 at the completion of treatment.

I have read and understand the financial policy of this office.

Signature_____ Date_____

Medical History

Patient Name_____

Physician_____ Phone ( )_____

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

For what?_____

2. Have you been hospitalized during the past two years? ☐ Yes ☐ No

For what?_____

3. Are you now taking any medicines or drugs, including aspirin? ☐ Yes ☐ No

If yes, which?_____

4. Are you allergic to any drugs or materials (for example: penicillin, metals, latex, etc.)? ☐ Yes ☐ No

If yes, which?_____

5. Have you ever had major surgery? ☐ Yes ☐ No For what?_____

When?_____

6. Please circle any of the following, which you have had or have at present:

CIRCULATORY SYSTEM

Heart attack / Surgery
(Artificial heart valves)
Angina
HBP
Stroke
Heart murmur / MVP
Congenital heart disorder
Pacemaker
Anemia
Other blood disorders :_____
TB / HIV / AIDS

OTHER

Arthritis
Emphysema
Artificial Joints
Sinus problems
TMD / Joint pain
Osteoporosis

Rheumatic fever
Epilepsy / Seizures
Diabetes
Smoker / Tobacco use
Drug / Alcohol use
Thyroid Disease
Hepatitis
Kidney disease
Cancer Treatment / History

7. **WOMEN**: Are you pregnant or nursing? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. If there is any change in my medical status, or if my medicines change, I will inform the dentist as soon as possible. By signing this form I acknowledge that I have read it completely and understand its contents.

Date_____ Signature of Patient, Parent or Guardian_____

Date_____ Signature of Dentist_____

Medical Updates **Reviewed By**

Date _____ _____

_____ _____

_____ _____

DENTAL HISTORY

Patient Name_____

Date_____

What is your main dental problem or purpose of this visit?_____

Date of your last dental visit_____ Reason for your last visit_____

Do your have copies or access to any recent X-rays or dental records?_____

In respect to any previous dental treatment:	**Please Circle**
Have you ever had an allergic reaction?	YES NO
Have you ever had any complications during or following dental treatments?	YES NO
Have you ever been told you have gum disease?	YES NO
Do your gums bleed on brushing or flossing?	YES NO
Are any of your teeth sensitive to heat, cold or pressure?	YES NO
Do you grind your teeth or clench your jaws?	YES NO
Do you have pain or clicking in the jaw joints?	YES NO
Do you regularly have soreness in your jaw muscles?	YES NO
Are there any sores or growths in your mouth now?	YES NO
Do you want your teeth whiter?	YES NO
Have you ever been told to take antibiotics prior to dental treatment?	YES NO
Are you happy with the appearance of your smile?	YES NO
Do you have problems with bad breath?	YES NO

Is there anything else that you think we should know about your care and treatment in this office? (Explain)_____

_____

NOTICE OF PRIVACY/CONSENT FORM
HIPAA

PATIENT GIVING CONSENT

PRINT NAME: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We may use and disclose health information to call your home or other contact information to remind you of an appointment or that it is time to make an appointment at this office. You have the right to revoke this consent, in writing, signed by you, at any time. However, such revocation shall not affect any disclosure we may already have made in reliance on your prior consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPPA)

Notice of Privacy Practices: You have the right to review our Notice of Privacy Practices before signing. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our notice, you may obtain a revised copy by contacting our Practice Administrator.

The patient understands that:

1. **Information may be disclosed to other providers who may be involved in your continuing care and course of treatment directly and indirectly.**
2. **Information may be disclosed to obtain reimbursement from your insurance company that we have on file for payment to the provider or yourself for services performed.**
3. **Information may be disclosed for all billing and collection activities.**
4. **We may contact your at your home or via other contact information you provided us with to confirm you appointment or discuss treatment related information with you.**

* **The practice may condition rendering of treatment upon the execution of this consent.**

SIGNATURE: _____ **DATE:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following…

Personal Representative's Name: _____

Relationship to Patient: _____

DENTAL INSURANCE INFORMATION

Is the Patient covered by Dental Insurance? YES NO (Please Circle). If Yes, please provide our receptionist with your Driver's License and all Dental Insurance Cards so a copy can be included in the chart, as insurance companies require proof of identification.

INFORMATION ABOUT INSURED

Last Name_____ First Name_____ MI_____

Soc. Sec. #_____ Birthdate_____ Relation to Patient_____

Employer Name_____ Employer Phone ( )_____

Employer Address_____

City_____ State_____ Zip_____

If you have Dental Insurance Coverage and are an established patient in this office:
After your insurance benefits are verified, and as an added service to our patients, we will submit your insurance claims for you, and accept assignment of your balance from your primary insurance carrier only. We do not get involved with secondary insurance companies or Cobra plans; this will be your responsibility You will be responsible for all deductibles and estimated co-payments at the time services are rendered. Some insurance companies have an undisclosed fee schedule or will only reimburse the insured and NOT the provider. In these cases, payment is expected in full, and you will get reimbursed from your insurance company.

I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the dentist; therefore, my insurance company may pay less than the actual bill for services and I am still responsible for all dental fees incurred.

Permission To Release Health Information and Assignment of Benefits to Dentist. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers (and-or other health practitioners) and I authorize payment of any Insurance benefits to: Oivind Jensen, DDS and Sean P Carr, DDS

SIGNATURE_____ DATE_____

If Patient is a Minor:
Parent's Signature_____

Permission to Release Health Information Only:
I grant the right to release health information obtained from me, and information about my dental treatment to third party payers (and/or other health practitioners).

SIGNATURE_____ DATE_____

If Patient is a Minor:
Parent's Signature_____