Jacobsen
FAMILY DENTISTRY

PATIENT INFORMATION FORM

NAME:_____DOB:_____ /_____ /_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE:_____SS NO:_____

MARITAL STATUS:_____SEX:_____CELL PHONE:_____

BUSINESS NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SPOUSE OR PARENT NAME:_____PHONE NO:_____

HOW DID YOU HEAR ABOUT US?:_____

CONTACT INCASE OF EMERGENCY

NAME:_____PHONE NO:_____

PRIMARY INSURANCE COVERAGE

INSURED'S NAME:_____DOB:_____ /_____ /_____

RELATION TO PATIENT:_____SS NO:_____GROUP NO:_____

EMPLOYER NAME AND ADDRESS:_____

_____

INSURANCE COMPANY NAME AND ADDRESS (FOUND ON CARD):_____

_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE?: YES:_____ NO:_____

Signature:_____DATE:_____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

PATIENT NAME_____ **HOME PHONE**_____
DOB_____ **BUSINESS PHONE**_____ **CELL PHONE**_____

PATIENT MEDICAL HISTORY

PHYSICIAN_____ OFFICE PHONE_____ DATE OF LAST EXAM_____

	YES	NO
1. Are you under medical treatment?	____	____
2. Have you ever been hospitalized for any surgical operation or serious illness?_____		
3. **List any medication(s) and dosage including supplement or vitamins.**_____		
4. Give a written list of medication to the Receptionist.		
5. Are you currently on Bisphosphonates?	____	____
6. Are you being treated for Osteoporosis?	____	____
7. Are you being treated for Anxiety?	____	____
8. Do you use tobacco, cigarettes or smokeless?	____	____

9. Have you had Chemotherapy?_____
Oncologist_____

ALLERGIC TO ANY OF THE FOLLOWING:

YES	NO		YES	NO	
____	____	Local Anesthetics	____	____	Barbiturates
____	____	Penicillin or other antibiotics	____	____	Sedatives
			____	____	Aspirin
____	____	Sulfa drugs	____	____	Other
____	____	**Latex**	_____		

WOMEN ONLY	YES	NO
a) Are you pregnant or think you may be pregnant?	____	____
b) Are you nursing?	____	____
c) Are you taking birth control pills?	____	____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
____	____	High Blood Pressure	____	____	Cardiac Pacemaker	____	____	Stomach Troubles/Ulcers
____	____	Heart Attack	____	____	Heart Murmur	____	____	Stroke
____	____	Artificial Heart Valve	____	____	Mitral Valve Prolapse	____	____	Hay fever / Allergies
____	____	Angina / Chest Pains	____	____	Asthma	____	____	Tuberculosis
____	____	Heart Disease	____	____	Emphysema / COPD	____	____	Glaucoma
____	____	Epilepsy / Convulsions	____	____	Cancer-Type _____	____	____	Recent Weight Loss
____	____	Fainting / Seizures			Last treatment? _____	____	____	Liver Disease
____	____	Kidney Disease	____	____	Released for dental treatment?	____	____	Thyroid Problem
____	____	Joint Replacement	____	____	Chemotherapy	____	____	Arthritis
____	____	AIDS / HIV Infection	____	____	Radiation Therapy	____	____	Hepatitis A, B, or C
____	____	Diabetes	____	____	Leukemia	____	____	Other_____
____	____	Anemia	____	____	Sexually Transmitted Disease			_____

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	____	____
2. Are your teeth sensitive to hot or cold?	____	____
3. Are your teeth sensitive to sweet or sour?	____	____
4. Do you feel pain to any of your teeth?	____	____
5. Do you have any sores or lumps in your mouth?	____	____
6. Have you ever experienced any of the following problems in your jaw?	____	____
a) Clicking?	____	____
b) Pain (joint, ear, side or face)?	____	____
c) Difficulty in opening or closing?	____	____
d) Difficulty in chewing?	____	____
7. Have you had any head, neck or jaw injuries?	____	____

	YES	NO
8. Do you have frequent headaches?	____	____
9. Do you clench or grind your teeth?	____	____
10. Do you bite your lip or cheeks frequently?	____	____
11. Have you ever had any difficult extractions?	____	____
12. Have you had any orthodontic treatment?	____	____
13. Have you ever prolonged bleeding following extractions?	____	____
14. Have you ever had instruction on brushing?	____	____
15. Have you ever had instruction on the care of your gums?	____	____

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.

SIGNATURE X_____DATE_____
PATIENT, PARENT OR GAURDIAN

Jacobsen
FAMILY DENTISTRY

OFFICE FINANCIAL POLICY

To avoid misunderstandings and make you aware of our financial policies, we wish to provide you with the following information:

1. **Diagnostic and consultation services:** Fees for diagnosis, consultation, x-rays, or other similar serves, such as emergency services, are due at the completion of your appointment. If you have questions about the amount, please ask the receptionist when scheduling the appointment. If you have insurance coverage, your estimated copay is due when services are rendered. This is an estimated fee and the balance is due within 30 days of insurance payment.

2. **Restorative treatment:** Payments for restorative services are due in full when treatment is complete. For major dental procedures including crowns, dentures, bridges, and partials, we require that at least one half of the estimated cost be paid when treatment is initiated. The remaining half will be due at the completion of treatment. If additional treatment is required, Dr. Strong or Dr. Jacobsen will advise you before treatment is initiated.

3. Consecutive missed appointments may be subject to a fee.

OUR OFFICE WILL HONOR VISA, MASTERCARD, AMEX, CARE CREDIT, AND DISCOVER

STRONG AND JACOBSEN MEMBERSHIP PLAN WILL BE RECOGNIZED IF MEMBERSHIP IS CURRENT

IN THE EVENT THAT YOUR ACCOUNT IS TURNED TO COLLECTIONS THERE WILL BE A $30.00 SERVICE CHARGE.

ALL RETURNED CHECKS FOR INSUFFICIENT FUNDS WILL BE CHARGED $30.00

We assure you that we will do our best to provide the highest quality dental care possible.

Please note: We are happy to file your insurance. Please inform us of any changes in your policy. You are ultimately responsible for your bill.

Signature_____ Date: _____