Legacy FAMILY DENTISTRY

DENTAL REGISTRATION

Kristin Jorgensen, D.D.S., P.C.

PATIENT INFORMATION

Date_____ Home Phone (_____) _____ Cell Phone (_____) _____

Name _____ SS# _____
Last Name First Name Middle Initial

Address_____ E-mail_____

City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age_____ Birthdate _____ ❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone (____)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (_____)_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone (_____)_____

City _____ State _____ Zip _____

Person Responsible Employed by_____ Occupation _____

Business Address _____ Business Phone (_____)_____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name_____Birthdate_____ Relation to Patient _____

Address (if different from patient's) _____ Phone (_____)_____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (_____)_____

Insurance Company_____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan_____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s), have insurance coverage with_____and assign directly to
Name of Insurance Company(ies)

Dr. Kristin Jorgensen/Legacy Family Dentistry all insurance benefits, if any, otherwise payable to me for services renedered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to my insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will continue as long as I remain a patient of Legacy Family Dentistry.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

DENTAL HEALTH HISTORY
(Confidential)

Legacy FAMILY DENTISTRY

Kristin Jorgensen, D.D.S., P.C.

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following or have questions for the doctor:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth
- ❑ Cosmetic proceedures desired _____
- ❑ Interested in knowing more about _____

MEDICAL HISTORY

Physcian's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva ❑ Yes ❑ No

Have you had any serious illnesses or operations? _____ if yes, describe _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates _____

Check (✓) if you have or have had any of the following:

- ❑ Abnormal Bleeding
- ❑ Anemia
- ❑ Allergies
- ❑ Arthritis, Rheumatism
- ❑ Artifical Heart Valves
- ❑ Artifical Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Thinners
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Dementia
- ❑ Developmental Disorders
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Herpes
- ❑ Heart Problems
- ❑ Hepatitis, Type_____
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mental Disorders
- ❑ Osteoporosis/Rx's
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Shortness of Breath
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tuberculosis
- ❑ Ulcer

Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

MEDICATIONS

List medications you are currently taking, including supplements or vitamins

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (Sleeping pills)
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Latex _____
- ❑ Other _____

_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **24 hour advanced notification** so that we may use our time to accomodate other patients. Broken and missed appointments create scheduling problems for our patients and our practice; **we reserve the right to charge a minimum of $35.00 missed appointment fee if appointments are missed or broken frequently.**

FINANCIAL POLICY

Payment in full is due the day of treatment. Should a patient have dental insurance with assignment to Legacy Family Dentistry, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

Payment Options

1. For your convenience we accept **Cash, Check, Visa, MasterCard, Amex, Discover**.
2. We also offer short and long-term financing through partners such as **Care Credit**. Interest-free options are available.

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you.

Finance Charge and Fees

- Balances in execess of 30 days are subject to a finance charge of 1.5% per month (18% annual).
- Returned checks are subject to a $30 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Legacy Family Dentistry. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Legacy Family Dentistry to release any information regarding my dental/medical history, diagnosis or treatment to third party payors (e.g. Insurance Companies) and/or other health professionals working on my behalf.

Assignment of Insurance Benefits

I authorize and request my Insurance company to pay my benefits directly to Legacy Family Dentistry.

Photography Release

I authorize Legacy Family Dentistry to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize them to show these clinical photographs to other patients to better explain their treatment options.

I understand that my privacy will be protected **at all times**.
I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.

X _____ Date _____

Signature of patient, parent or guardian

NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION

I hereby acknowledge that I have had the opportunity to review this practice's Notice of Privacy Practices.
I understand that I may ask any questions I might have regarding this notice, and I may request a copy of these policies.

Signature _____ **Date** _____

PARENTS OF MINOR CHILDREN

If this form is for a minor child (17 years or younger), please note that it is the policy of this practice that ALL minor children are to have a legal guardian present in the office during the entire appointment.

If an unusual circumstance should arise where the guardian/parent cannot be present, a separate consent form must be completed & signed before that patient can be seen for their appointment, and arrangements are made for payment due on that day. We appreciate your understanding & compliance with this policy.

Please ask for this consent form at the front desk.

ELECTION TO SHARE INFORMATION

Please be aware that due to privacy laws, we are unable to share any information (health or financial, with anyone unless so specified in our Privacy Policies or in the case of a parent-minor child relationship) without your expressed permission. If you would like us to be able to share such protected information, please indicate to whom you authorize us to discuss such matters:

1) _____

2) _____

3) _____

Your Signature _____ **Date** _____

*THIS AUTHORIZATION REMAINS IN EFFECT UNTIL REVOKED BY YOU