JENKINS DENTAL CARE

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help. Whom may we thank for referring you? ____

ABOUT YOU

Name: ___________________________ I prefer to be called______________________________ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: _____________________________

Home Address: ____ City____________State____Zip________

Home Phone: (____) ______________ Work: (____) ______________ ext. ___ Pager: (____) ______________

Cell: (____) ________________ E-mail Address: ____

Employer: ___________________________ How long there? _______________ Occupation: _________________

Employer's Address: ________________________________ City_______________ State________ Zip___________

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _________________________________ Birth date:___/___/___ Relation: ______________

Billing Address: ____ City____________State____Zip________

Home Phone: (____) ________________ Work: (____) ________________ S.S. #: ___________________________

Employer: _________________________________ How long there? _________ Occupation:___________________

SPOUSE INFORMATION

[ ] Same as above Name: ____ Birth date: ___/___/___

Employer: ____ Work Phone: (____) ___________ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: ___________________________ Phone: (____) ________ Group/Policy #: ________________

Insured's Name: _______________________________ Insured's Birth date: ___/___/___ Relation: ________________

Insured's Social Security #: ____________________________ Insured's Employer: ___________________________

Secondary Insurance

Insurance Co. Name: ___________________________ Phone: (____) ________ Group/Policy #: ________________

Insured's Name: _______________________________ Insured's Birth date: ___/___/___ Relation: ________________

Insured's Social Security #: ____________________________ Insured's Employer: ___________________________

MEDICAL HISTORY INFORMATION

Name of Physician: ____ Phone: (____) ________________________

Pharmacy Preference: ____

MEDICAL ALERTS: Please inform the office if health conditions or medications change. *This condition may require antibiotic pre-medication for certain dental procedures. Please check those that apply:

[ ] ADHD/ADD	[ ] Diabetes	[ ] Heart Surgery	[ ] Rheumatism
[ ] Allergies/Hay Fever	[ ] Epilepsy or Seizures	[ ] Hepatitis	[ ] Sickle Cell Disease
[ ] Anemia	[ ] Excessive Bleeding	[ ] High Blood Pressure	[ ] Sinus Problems
[ ] Angina	[ ] Excessive Thirst	[ ] HIV*/AIDS	[ ] Stent* __/___/____
[ ] Arthritis	[ ] Fainting or Dizziness	[ ] Kidney Problems	[ ] Stroke
[ ] Artificial Joints*______	[ ] Fever Blisters/Cold Sores	[ ] Liver Problems	[ ] Surgical Shunt*
[ ] Artificial Heart Valves*	[ ] Frequent Cough	[ ] Mental Disorders	[ ] Thyroid Problems
[ ] Asthma	[ ] Glaucoma	[ ] Mitral Valve Prolapse*	[ ] Tuberculosis
[ ] Breathing Problems	[ ] Heart Problems*	[ ] Osteoporosis	[ ] Ulcers
[ ] Cancer	[ ] Heart Infection	[ ] Radiation Treatment	[ ] Venereal Disease
[ ] Chemical Dependency	[ ] Heart Murmur	[ ] Respiratory Problems	
[ ] Chemotherapy	[ ] Heart Pace Maker	[ ] Rheumatic Fever	

YES NO (Please mark below)

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?

If yes, explain: ____

[ ] [ ] Are you now under the care of a physician? If yes, explain: ____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, explain: ____

[ ] [ ] Are you taking any medications including blood thinners or bone-strengthening medications? If yes, list:

____

[ ] [ ] Are you CURRENTLY taking or have you EVER TAKEN any of the following medications?

___Alendronate (Fosamax) ____Risedronate (Actonel) ____Ibandronate(Boniva) ___ Pamidronate(Aredia)

___Zoledronate (Zometa/Reclast) ____Denosumab(Xgeva/Prolia) ___Sunitinib (Sutent)

___Sorafenib (Nexavar) ____Bevacizumab (Avastin) ____Sirolimus(Rapamune)

[ ] [ ] Are you allergic to any medications or substances? If yes, please check box below:

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other ______________________

[ ] [ ] Do you use tobacco? If yes, explain: ____

WOMEN (Please check): [ ] Pregnant (due date ___________ [ ] Nursing [ ] Trying to get pregnant [ ] Not pregnant

[ ] Taking oral contraceptives

DENTAL HISTORY INFORMATION

PREVIOUS DENTIST: ____

LAST VISIT DATE WITH ABOVE DENTIST: ____

LAST CLEANING DATE: _____________________________

Please help us better understand your dental health needs and goals by answering the following questions.

(check the best answer):

1. Have you had a dental cleaning in the past 6 months? [ ] Yes [ ] No

2. I have a [ ] low [ ] moderate [ ] high fear of going to the dentist.

3. My mouth and teeth are [ ] very [ ] moderately [ ] not comfortable.

4. I am [ ] very satisfied [ ] satisfied [ ] dissatisfied with the appearance of my teeth.

5. I think my present state of dental health is [ ] excellent [ ] good [ ] fair [ ] poor.

6. My gums bleed [ ] every time I brush my teeth [ ] on occasion [ ] never.

7. My main concerns with my dental health are: ____

Please check which statement below best represents the level of dental health you wish to achieve.

[ ] **HEALTH LEVEL I - Emergency Care**

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment.

I am not very interested in thinking about the future of my teeth at this time.

[ ] **HEALTH LEVEL II - Maintenance Care**

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

[ ] **HEALTH LEVEL III - Comprehensive Care**

I am interested in comprehensive care to achieve and maintain a higher level of dental health.

I am concerned about treating the causes of dental diseases, not simply the effects.

I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

[ ] **HEALTH LEVEL IV - Comprehensive & Cosmetic Care**

I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health.

I am concerned about treating the causes of dental diseases, not simply the effects.

I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.

CONSENT, ASSIGNMENT AND RELEASE

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 2 working days advanced notification so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. Otherwise, a missed appointment fee of $25.00 may be charged to your account. We value your time, please value ours.

I, ______________________________, have had full opportunity to consider the contents of this consent form. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out only necessary treatment, payment activities, and health care operations.

Being the parent or guardian of ____________________________, I do hereby request and authorize Jenkins Dental care to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered. Children under the age of 18 should be accompanied by an adult to all appointments unless previously authorized by Jenkins Dental Care.

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Adult Patient / Guardian Signature

I, the undersigned, have insurance with ____ insurance company and assign directly to Jenkins Dental Care all benefits, in any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. As a courtesy, we estimate your portion for payment under insured claims; however, **I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY MY INSURANCE.**

I give my permission to all patient members covered under my insurance, to use my benefits allowed through my insurance plan. I understand that by signing this, any charges incurred by the members listed below not covered by my insurance will be my responsibility. I authorize the use of this signature on all of my insurance submissions whether manual or electronic.

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Adult Patient / Guardian Signature

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. **A $25.00 collection fee will be assessed to all unpaid balances 75 days and over. A $30.00 fee will be added to all returned checks.** I accept all finance charges up to 18% and all billing charges added to my account accruing after 60 days.

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Adult Patient / Guardian Signature

********* I have received and reviewed copies of the ADA translation assistance guidelines as well as the HIPAA Mandated privacy policy***

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Adult patient/Guardian Signature