Kathy Jacobsen
CONTEMPORARY DENTISTRY

Patient Information

Name _____ SS# _____

Address _____ Birth Date _____

City _____ State _____ Home Phone _____

Zip _____ Wk Phone _____

Sex: Male / Female Cell Phone _____

Single Married Widowed Separated Divorced Domestic Partner

Employer _____ Email Address _____

Whom may we thank for your referral _____

Dental Insurance

Responsible party _____ Relationship to Patient _____

Birth date _____ SS# _____

Insurance Company _____ Phone _____

Employer _____ Group # _____

Employer Address _____

In an Emergency (Not in your household)

Name _____ Phone _____

Relationship _____ Alt Phone _____

Assignment and Release

I, the Undersigned certify that I (or my dependent) have insurance coverage with _____ and assign benefits directly to Dr. Kathy Jacobsen. I am responsible for total charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on al insurance submission.

_____ _____ _____

Responsible party signature Relationship Date

Medications

List any medications that you are currently taking and the correlating diagnosis.

_____

_____

Pharmacy

_____ Phone _____

_____

Allergies

- ❑ Local Anesthetic
- ❑ Penicillin or antibiotics
- ❑ Codeine/ Valium / sedatives
- ❑ Latex
- ❑ Aspirin
- ❑ Other _____

Health History

Physicians Name _____ Date of last visit _____

Reason _____

_____ Hospitalization(s) _____

_____

Check if you have had any of the following:

- ❑ AIDS/HIV +
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Endocarditis
- ❑ Bleeding abnormally
- ❑ Bypass
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Dialysis
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting or dizziness
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart problems
- ❑ Hepatitis Type____
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Immunosuppressed
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lupus
- ❑ Mental Disorder
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker/ Defibrillator
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of breath
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Stroke
- ❑ Surgical Shunts
- ❑ Swelling of the feet or ankles
- ❑ Swollen Neck Glands
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumor or growth on head or neck
- ❑ Ulcer
- ❑ Valvular Dysfunction
- ❑ Smoker ____ pack(s)

Women

- ❑ Pregnant: Due_____
- ❑ Nursing
- ❑ Birth control

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Dental Health History

Patient's Name: _____ Date: _____

1. Is keeping your teeth important to you? [Y] [N]
   If yes, why? _____
2. When was your last cleaning? _____
3. How often do you brush?_____
4. How often do you floss?_____
5. On a scale of 1-10, 10 being the best,
   Where would you rate your smile? _____ Where would you rate your oral health? _____
6. Have you experienced any of the following problems:

Bleeding Gums [Y] [N]	Sensitivity to hot or cold [Y] [N]
Bad breath or sour taste in mouth [Y] [N]	Snoring [Y] [N]
Burning sensations in mouth [Y] [N]	Food catching between teeth [Y] [N]
Soreness in jaw [Y] [N]	Grinding of Teeth [Y] [N]
Is it hard for you to open wide? [Y] [N]	Pain/ soreness around the ears,eyes,face [Y] [N]
Clicking or popping in jaw [Y] [N]	Stiff neck muscles [Y] [N]
Dry Mouth [Y] [N]	Headaches/ Migraines [Y] [N]

7. Does having dental treatment make you afraid or nervous? [Y] [N]
   If yes, what specific things bother you? _____
8. Have you ever had a less than positive dental experience? [Y] [N]
   If yes, what did you dislike about that experience? _____
9. If you could change anything from your smile which of the following would you want?

Whiter [Y] [N]	Straighter [Y] [N]
Replace missing Teeth [Y] [N]	Less Gum showing [Y] [N]
Excess showing of Teeth [Y] [N]	Replace old filling(s) [Y] [N]
Reshape/resize my teeth [Y] [N]	Replace chipped Teeth [Y] [N]
Close space or spaces [Y] [N]	Replace old crowns [Y] [N]
Remove Stains/ Spots on teeth [Y] [N]	Remove silver fillings [Y] [N]

10. Where do you see yourself and your overall oral health and/ or your smile in the next 5 to 10 years?
11. Please circle the following which are important to you when making your dental health decision.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

12. Something fun about yourself_____
13. What do you like to do in your free time?_____

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Dental Consent

1. I hereby authorized Kathy Jacobsen, D.M.D. and her team to perform the following dental treatment including the use of any necessary local anesthesia, x-rays, or diagnostic aids. All treatment was explained to me prior to initiation of treatment.
    A. Preventative hygiene treatment, (cleaning), application of topical fluoride and application of sealants.
    B. Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
    C. Extraction of one or more teeth.

2. I understand that there are risks involved in this treatment and herby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. Dr. Jacobsen will stop and explain any deviation from original treatment plan.

5. I understand that failure to proceed with treatment can lead to adverse effects.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and publication. Likeness may be used in our books or website.

I have read and understand the material above.

Print Name: _____

Signature:_____ Date:_____

Parent or Guardian if minor:_____

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HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This signed agreement acknowledges receipt of our Notice of Privacy Practices and documents our good faith effort to obtain that acknowledgement*

*You may refuse to sign this acknowledgement

I have received a copy or explanation of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient / Guardian Date

Relationship to Patient> Self or Other_____

For Office Use Only

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

- Individual refused to sign
- Communications challenges (such as a language barrier) which prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement at time of service
- Other (Please specify)

_____

_____

Representative for Dr. Kathy Jacobsen – Contemporary Dentistry

_____

Date

_____

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Financial Policy

Thank you for choosing Contemporary Dentistry!

We understand that dental care is an important investment, and we strive to make it accessible to everyone. We offer a variety of payment options to help you receive the dental care you need and deserve, while respecting your budget.

Financial Options at Contemporary Dentistry:

1. **Pre-Payment Discount:** Receive a 5% courtesy discount for all treatment paid in full before or on the treatment start date.
2. **Short-Term Financing Options:** We offer flexible financing plans for treatment costs with a 25% down payment. Choose the plan that best suits your needs:
   - 3 months – 12% interest
   - 6 months – *18% interest*
   - 12 months – *28% interest*
3. **Cherry Financing:** We partner with Cherry Financing to offer flexible payment plans with soft credit checks. Cherry approves patients with a credit score of 520 or higher. You can customize your monthly payment to comfortably fit your budget. Visit https://tree.withcherry.com/contemporary-dentistry to learn more and apply.
4. **Other Payment Options:** We also accept Care Credit, major credit cards, debit cards, cash, and checks.
   - We offer a 5% discount for all balances paid with cash or a check.

Please note: Contact our office for the most up-to-date interest rates on our short-term financing plans.

Insurance: At Contemporary Dentistry we accept and file claims for all major PPO dental plans.

Broken Appointment Policy:

We understand that unforeseen circumstances may arise. However, a specific amount of time is reserved exclusively for your appointment. If you need to reschedule or cancel, we require at least 48 hours' notice. Failure to provide sufficient notice will result in a $75 per hour cancellation fee. We appreciate your understanding in this matter.

Print Name: _____ Date: _____

Signature: _____

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Dr. Jacobsen and her team would like to welcome you to Contemporary Dentistry. At this time, we would like to take this opportunity to explain our office guidelines.

APPOINTMENTS: We recognize the value of your time and we do our very best to see you as promptly as possible. If there are any delays in your appointment time, our team will let you know right away. It is important that you come to your appointment at your scheduled time. If you are more then **15 minutes late**, we will have to reschedule your appointment.

YOUR VISITS WILL INCLUDE YOUR OPTIONS FOR:

- Quality time with our team
- State of the art technology
- Visual tour of your mouth
- Sterilization methods of the highest standards
- Review of your digital x-rays
- Treatment estimates given in writing before you schedule your treatment

OUR GUARANTEE: Dr. Jacobsen is proud to guarantee her work. We give a **Five**-year guarantee on treatment received in our office. We extend this guarantee to our patients that complete all recommended treatment and keep all recommended hygiene and restorative appointments.

EMERGENCIES: Dental emergencies arise from time to time. When they do, please call our office immediately. When we are out of office you can call the office and be forwarded to Dr. Jacobsen directly.

DENTAL INSURANCE: We are happy to file the forms necessary to see that you receive the optimal benefits of your coverage; however, we cannot guarantee any **estimated** coverage. We are an unrestricted insurance provider and can file claims for all PPO plans.

CANCELLATIONS OR BROKEN APPOINTMENTS: We are able to extend a **"No Charge"** fee to our patients who give us a 2-business day notice if unable to keep your scheduled appointment. A $75.00 charge will be required per patient per hour for each appointment that is not cancelled prior to 48 business hours.

CHILDREN AND OUR OFFICE: Please understand that we do love children and providing care for them. However, we are unable to accommodate children in our office unless they have a scheduled appointment with the Doctor or Hygienist. If you cannot find a babysitter for your child, please reach out to let us know.

PATIENT CONFIDENTIALITY: I acknowledge that I received the office Privacy Practices and understand their contents. Any questions have been discussed to my satisfaction.

_____ Patient Name _____ Date