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
- ❑ Asprin
- ❑ 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:_____

Kathy Jacobsen
CONTEMPORARY DENTISTRY

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve, that allows you to enjoy a healthy, beautiful smile with respect to your budget.

Financial Options:

1. **Pre-Payment Discount:** We offer a 5% accounting courtesy for all treatment for which your co-pay is PAID IN FULL (cash or check) 1 week prior to service.
2. **Major Service-Two Payment Option:** We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the seat/delivery date appointment.
3. **Compassionate Finance:** We offer financing that approves everyone with a checking account in good-standing, and you get to request a monthly payment that would comfortably fit your budget.

Payments are expected at the time services are rendered. We accept cash, checks, debit cards, and all major credit cards.

Broken appointments: A specific amount of time is reserved specifically for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least a 48 hour notice to avoid a $50.00 per hour cancellation fee.

Print name: _____ Date: _____

Signature: _____

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

_____