**Dillion Jensen D.D.S.**

**Patient Registration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(801)\_485-2627**

**Welcome!**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Last First MI**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_/\_\_\_\_/\_\_\_\_**

 **Street Apt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **City State Zip Code**

**Home Phone: ( )\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M / F**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name Relationship**

* **Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Which is best to confirm appointments? CIRCLE: Home Work Cell E-mail**

**Account Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person responsible for this account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Billing address (If different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured Person’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Street City State Zip**

**Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental Health History**

**\_\_\_\_\_Confidential\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Last First MI**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dental History\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Former Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Dental care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last Dental X-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you like your smile? [] Yes [] No**

**Have you had problems with any of the following?**

 **[] Bad Breath [] Grinding Teeth [] Sensitivity to hot or cold**

 **[] Bleeding Gums [] Loose Teeth [] Broken Fillings**

 **[] Sensitivity to Sweets [] Clicking or Popping Jaw [] Periodontal Treatment**

 **[] Sensitivity to Biting [] Food Collection Between Teeth [] Sores or Growths in Your Mouth**

**How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you interested in bleaching your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical History\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any serious illnesses or operations? [] Yes [] No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had a blood transfusion? [] Yes [] No If yes, give approx. date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever taken any medications that contain Bisphosphonates? [] Yes [] No**

**(Women) Are you pregnant? [] Yes [] No Nursing? [] Yes [] No Taking birth control? [] Yes [] No**

**Check any that apply to you:**

**[] Anemia [] Cortisone treatments [] High Blood Pressure [] Shortness of Breath**

**[] Arthritis, Rheumatism [] Cough, Persistent [] HIV/AIDS [] Skin Rash**

**[] Artificial Heart Valve [] Diabetes [] Jaw Pain [] Stroke**

**[] Artificial Joints [] Epilepsy [] Kidney Disease [] Swelling**

**[] Asthma [] Fainting [] Liver Disease [] Thyroid Problems**

**[] Back Problems [] Glaucoma [] Mitral Valve Prolapse [] Tobacco Habit**

**[] Blood Disease [] Headaches [] Pacemaker [] Tonsillitis**

**[] Cancer [] Heart Murmur [] Radiation Treatment [] Tuberculosis**

**[] Chemical Dependency [] Heart Problems [] Respiratory Disease [] Ulcer**

**[] Chemotherapy [] Hemophilia [] Rheumatic Fever [] Venereal Disease**

**[] Circulatory Problems [] Hepatitis [] Scarlet Fever**

**Allergies:**

**[] Aspirin [] Codeine [] Latex [] Local Anesthetic [] Penicillin [] Sleeping Pills [] Sulfa [] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**List medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Saltwater Dental**

**Agreement to Pay for Dental Services**

I agree to pay for all services provided to me or to members of my family by Saltwater Dental. I understand that Saltwater Dental will, as an accommodation to me, seek payment from insurance company for amounts covered by insurance. I understand, however, that ***IF MY INSURANCE PROVIDER DOES NOT PAY*** for the dental service, I am ultimately responsible to pay all amounts owing in full within 90 days from the date of service unless Saltwater Dental has agreed to other payment arrangements.

If I fail to pay the balance owed in full when due, I agree I will be responsible for interest at the rate of 18% annually, calculated from the date of service. If my account is sent to collections, I agree that in addition to any amount left owing to Saltwater Dental, I will be responsible for a collection fee, court costs and reasonable attorney’s fees, with or without suit, incurred in collecting any past due balance.

**I understand that I will be charged a fee of $50** if I cancel a scheduled appointment with Saltwater Dental within twenty-four hours of the appointment. I understand further that, due to office policy and certain insurance contracts, appointment cancellation fees are not negotiable and will not be removed from my statements. I also understand that Saltwater Dental does not accept any cancellations by voicemail.

I authorize Saltwater Dental to obtain a consumer credit report in connection with the credit extended on my account. If there is any conflict between the terms and this Agreement and the patient-intake forms, the terms of this Agreement supersede the patient-intake forms.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Saltwater Dental**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*\* You May Refuse to Sign This Acknowledgement\*\*

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)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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