Patient Information

Patient Name: _____ Date of Birth: _____
Last First MI Preferred name

Address: _____ Email: _____
Street City State Zip

Phone (home): _____ (cell): _____ (work): _____

Gender: ○ Male ○ Female Marital status: _____ SSN: _____

How did you hear about our office? _____

Health Information

Date of last dental visit: _____ Reason for today's visit: _____

Do you have any allergies to medications? ○ Yes ○ No

If yes, please describe: _____

Have you been told you need to premedicate prior to dental treatment? ○ Yes ○ No

If yes, please describe: _____

Are you under the care of a physician? ○ Yes ○ No

If yes, please describe: _____

Physicians Name: _____ Phone: _____

Are you taking any medications? ○ Yes ○ No

If yes, please list: _____

Do you use tobacco? ○ No ○ Smoke ○ Smokeless Do you drink alcohol? ○ Yes ○ No How much/often: _____

Have you ever had, or do you have any of the following? Please check all that apply:

□ AIDS/HIV	□ COPD	□ High Blood Pre	□ Rheumatic Fe
□ Allergies	□ Diabetes	□ Kidney Disease	□ Rheumatism
□ Anemia	□ Dizziness	□ Latex allergy	□ Seizure Disorc
□ Arthritis	□ Epilepsy	□ Liver Disease	□ Shortness of E
□ Artificial Joints	□ Fainting	□ Low Blood Pres	□ Sinus Problem
□ Asthma	□ Glaucoma	□ Mental Disorde	□ Stomach Diso
□ Blood Disorders	□ Head/Jaw pain	□ Nervous Disorc	□ Stroke
□ Cancer/Cancer trea	□ Heart Disease	□ Pacemaker	□ Tuberculosis
□ Chest Pain	□ Heart Murmur	□ Pregnancy	□ Ulcers
□ Congenital Heart D	□ Hepatitis	□ Respiratory Prc	□ Other_____

To the best of my knowledge, all the preceding answers and information provided are true and accurate. If I have a change in my health, I will inform the doctor at the next appointment without fail.

Signature: _____ Date: _____

Dr. Signature: _____ Date: _____

Responsible Party Information

Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip

Phone (home): _____ (cell): _____ (work): _____

Gender: ○ Male ○ Female Marital status: _____ SSN: _____

Relationship to the patient: _____

Employer name: _____ Occupation: _____

Employer Address:_____
Street City State Zip

Insurance Information

Primary Carrier:
Name of insured: _____ Is the insured the patient? ○ Yes ○ No
Last First MI

Insured's Date of Birth: _____ID #: _____ Group #: _____

Insurance company name: _____

Insurance company Address: _____

Secondary Carrier (if applicable):
Name of insured: _____ Is the insured the patient? ○ Yes ○ No
Last First MI

Insured's Date of Birth: _____ID #: _____ Group #: _____

Insurance company name: _____

Insurance company Address: _____

Emergency Contact

Name of emergency contact: _____ Relationship to patient: _____
Last First MI

Address: _____
Street City State Zip

Phone (home): _____ (cell): _____ (work): _____

Informed Consent to Perform General Dentistry

PLEASE READ AND INITIAL SECTIONS 1-7 AND SIGN BELOW

_____**1. WORK TO BE DONE:** I authorize Danielle Jesensky, DMD and/or dental auxiliaries of their choice to perform diagnostic and preventative treatment including but not limited to examinations, radiographs (x-rays), preventative hygiene cleanings (prophylaxis), application of fluoride, and sealants. I further authorize the treatment of diseased or injured teeth and gums with dental restorations and/or removal of teeth, the replacement of missing teeth with dental prosthesis, and scaling and root planing if recommended. I understand that there are risks involved in any treatment and hereby acknowledge that these risks and alternatives have been explained to me and that I will have an opportunity to ask questions regarding the risks, benefits, and alternatives of all treatment options, including no treatment.

_____**2. DRUGS AND MEDICATIONS:** I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swelling, pain, itching, and/or anaphylactic shock. I agree to the use of local anesthesia. I understand there are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. Although rare, unexpected severe complications with anesthesia can occur and include the possibility of infection, swelling, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. If needed, I agree to the use of sedative drugs to combat apprehension and/or disruptive behavior.

_____**3. CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my oral health and well being in the professional judgment of the dentist.

_____**4. RECORDS:** I authorize the use of photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, scientific publications, and consultation with other doctors.

_____**5. SUCCESS:** I understand the success of the dental treatment to be provided will require that the patient follow the post-operative and post-care instructions given by the dentist and/or the dental auxiliaries and that regular hygiene and dental visits as scheduled by my dentist and his dental auxiliaries must be maintained.

_____**6.** I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I hereby authorize any of the doctors at this facility and/or dental auxiliaries to proceed with and perform the dental procedures and treatments as have been explained to me. I understand this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

_____**7.** I hereby state I have read and understand this informed consent form, and that all questions about the procedures have been answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

Patient name: _____ **DATE** _____

Patient/Guardian Signature_____

Office Financial Policy

Our fees are based on the quality of the products and materials we use and our experience in performing your scheduled treatment.

Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. We also realize that every patient's financial situation is different. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

Dental Insurance
It's important to remember that your insurance coverage is a contract between you, your employer, and your insurance company. Benefits and coverage vary significantly from plan to plan. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist you with the cost of dental care.

As a courtesy to our patients, we are happy to submit your claims for services. In order for us to do this, you must provide us with accurate and up-to-date insurance information. We will verify your coverage and plan before your appointment. With this, we will estimate the insurance portion and your co-payment. This may or may not be what the insurance company will actually pay. Your plan may base its dollar allowance on a usual and customary fee schedule which may not coincide with current fees in our area. We will do our best to help you receive maximum benefits. Patients are responsible for all balances incurred for services received.

Payment for Services
Payment is expected at the time of service. If you have dental insurance, we will provide an estimate of your co-payment and collect your portion at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express. We also offer Care Credit, an outside healthcare financing program that offers interest-free payment plans upon approval.

A late fee of 1.6% may be assessed monthly to accounts after 60 days. Any unpaid balance over 90 days will be considered delinquent and may be turned over to a collection agency. Fees may apply. Returned check fee is $35.00.

Minor Patients
Please plan to be present at appointments with your child under 18. If you cannot be there, please make prior arrangements with our staff. The parent accompanying the minor child is responsible for payment. In the case of a divorce, regardless of decree, the parent who brings the child and has signed the financial agreement is responsible to pay for the child's services. We are unable to bill separate parties; therefore parents can work out these details.

We understand that sometimes it is necessary to change your appointment. We ask that you kindly allow 48 hours when needing to alter any reserved appointment. Without this notice, we are unable to offer treatment to other patients that may have needed our care. We reserve the right to charge $35-65/hr for missed appointments without sufficient cancellation notice, dependent upon procedure scheduled and history of cancellations.

I hereby state I have read and understand the financial policies, and that all questions about the policies have been answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

Patient name: _____ DATE _____

Patient/Guardian Signature_____