# JENKINS DENTAL CARE

**PATIENT REGISTRATION**

***Today's Date:*** _____

**NAME:** _____ **SSN:** ___-___-___
LAST FIRST MI **MEDICAID#** _____

Address: _____ P.O. Box_____City _____State _____ ZipCode_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____Email Address:_____

Sex: M ___ F ___ Age: _____ Date of Birth: _____ Marital Status: Single ___Married___Widowed___Separated___Child ___

Employer: _____ Occupation: _____

Is your spouse/child our current patient? If yes, please list name_____

*In case of emergency, who should be notified? Phone#

***(Please list parent or guardian names(s) of minor child)*** **For insurance purposes, please list parent's social security number, date of birth and employer name.**

## DENTAL HEALTH HISTORY

Reason for today's Visit: _____Date of Last dental visit _____ Former Dentist_____

How often do you: Floss _____ Brush _____ Complications following any dental treatment? If yes, please explain_____

## MEDICAL HISTORY

Your Medical Doctor's name: _____City, ST located_____Date of Last visit_____

What **PHARMACY** do you use? _____City of Pharmacy_____

Please list **ALL medications** that you are **allergic** to: _____

Are you taking or have you ever taken Fosamax?_____Medications currently taking _____

## PLEASE CHECK ALL WHICH APPLY TO PATIENT

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | ADHD/ADD | | Excessive Bleeding | | Lidocaine Allergy | | Seizures |
| | Anemia | | Glaucoma | | Liver Disease | | Sickle Cell Anemia |
| | Arthritis | | Hay Fever | | Low Blood Pressure | | Stomach Problems |
| | Artificial Joints | | Head Injuries | | Lupus | | Stroke |
| | Asthma | | Headaches | | Mental Disorder | | Sulfa Allergy |
| | Blood Disease | | Heart Disease | | Multiple Sclerosis | | Swollen Neck Glands |
| | Blood Thinner | | Heart Murmur | | Nervous Disorders | | Thyroid Problems |
| | Cancer (Present) | | Heart Problems | | Pacemaker | | Tobacco Use |
| | Cancer (Previous/Remission) | | Hepatitis | | Pregnancy (NOW) | | Tuberculosis |
| | Cerebral Palsy | | High Blood Pressure | | **DUE DATE:** | | **Medicine Allergy (list)** |
| | Chemical Dependency | | HIV/AIDS | | Psychiatric Care | | |
| | Chemotherapy | | Jaundice | | Radiation Treatment | | |
| | Circulatory Problems | | Joint Replacement | | Respiratory Problems | | **Other:** |
| | Diabetes | | Kidney Disease | | Rheumatic Fever | | |
| | Epilepsy | | Latex Allergy | | Rheumatism | | |

Please list all other health issues not listed above: _____

If patient is child, what is his/her weight_____ Has patient been in hospital recently? _____If so, why?: _____

***Women:*** **Do you suspect that you are pregnant? _____ Are you breast feeding? _____**

How did you hear about Jenkins Dental Care? _____Who may we thank for referring you to us?_____

## CONSENT TO TREAT AND DISCLOSURE OF HEALTH INFORMATION

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.

**Signature: X** _____

**MINOR/CHILD CONSENT**

I, being the parent or guardian of _____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. **Signature: X** _____

## ASSIGNMENT AND RELEASE

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. I give my permission to all 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.

**Signature: X**_____

## FINANCIAL AGREEMENT

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 asscessed to all unpaid balances 75 days and over. A $30.00 fee will be added to all returned checks.** 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 accept all finance charges up to 18% and all billing charges added to my account accruing after 60 days.

**Signature: X**_____