PATIENT REGISTRATION

(Please Print) Today's Date: _____

Patient: _____ _____
(Last Name) **(First Name)** **(Preferred Name)** Social Security Number #

Address: _____

P.O. Box_____ City _____State _____ Zip Code _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M ___ F ___ Age: _____ Date of Birth: _____

Marital Status: Single___ Married___ Widowed ___ Separated ___ Child ___

Employer: _____Occupation: _____

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

In case of emergency, who should be notified? _____Phone#_____

(If patient is a child, where do parents work and Social Security numbers)

_____

DENTAL HEALTH HISTORY

Reason for today's Visit: _____

Date of Last dental visit _____ Former Dentist _____

How often do you: Floss _____ Brush _____

Have you ever had any complications following any dental treatment? If yes, please explain _____

MEDICAL HISTORY

Your Medical Doctor's name: _____Date of Last visit_____

In what City is this doctor located? _____

What **PHARMACY** do you use? _____

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

Are you taking or have you ever taken Fosamax _____

Please list all other medications you are currently taking _____

_____

Please check all of the following that you have or have had:

___AIDS/HIV (+)	___Allergies to Medicines	___Anemia	___Arthritis
___Asthma	___Artificial Heart Valves	___Blood Disease	___Cancer (Now)
___Cancer (Past)	___Chemical Dependency	___Diabetes	___Codeine Allergy
___Epilepsy	___Circulatory Problems	___Glaucoma	___Headaches
___Hepatitis	___Excessive Bleeding	___Heart Murmur	___Heart Problems
___Pacemaker	___ Radiation Treatment	___Kidney Disease	___High Blood Pressure
___Stroke	___Penicillin Allergy	___Tuberculosis	___Joint Replacement
___Sulfa Allergy	___Respiratory Disease	___Psychiatric Care	___Swollen Neck Glands
___Venereal Disease	___Tobacco Use	___Pregnancy/DUE DATE _____	

Please list all other health issues not listed above: _____

If patient is child, what is his/her weight____ Has patient been in hospital recently? ____

(Women) Do you suspect that you are pregnant? _____ Are you breast feeding? _____

How did you hear about Jenkins Dental Care? If a patient referred you to us, please list the name._____

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: _____

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.

Date: _____ **Signature:** _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
(Name of 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.

Date: _____ **Signature:** _____

*****Please list all members below that you wish to assume financial responsibility for that are covered under your insurance.**

_____

_____

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.

Date: _____ **Signature:** _____