

Dr Jepsen & Associates
A Professional Corporation

Doctor's Information Record

General Information

- A. Patients Name: First _____ Middle _____ Last _____ Female _____
- B. Social Security Number _____ Single ___ Married ___ Widowed ___ Male _____
- C. Address _____ City _____
Employer _____ Occupation _____
- D. Home Telephone _____ Business Telephone _____
- E. Who referred you to this office _____
- F. Last Dental Visit _____ Services Rendered _____
- G. Former Dentist _____
- H. Purpose of today's visit _____
- I. Spouse's first name _____ Spouse's Employer _____ phone _____

I. Dental History

- A. Age: _____ Height: _____ Weight: _____ Date of Birth: _____
- B. Physician's name and Location: _____ Phone: _____
- C. How many times have you had your teeth cleaned in the past 3 years: _____

- | | Yes | No |
|---|------------|-----------|
| D. Are you nervous about receiving dental treatment? | ___ | ___ |
| E. I would like more information about nitrous oxide (tranquilizing gas)? | ___ | ___ |
| F. Are you taking medicine of any kind? | ___ | ___ |
| G. Has there been any changes in your general health in the past year? | ___ | ___ |
| H. Do you have a guard/splint? | ___ | ___ |
| I. Are spaces developing between your teeth? | ___ | ___ |
| J. Would you be tremendously disturbed to lose all of your teeth? | ___ | ___ |
| K. Have you had any "gum boils" or gum swelling? | ___ | ___ |
| L. Are you dissatisfied with the appearance of your teeth? | ___ | ___ |
| Specify _____ | ___ | ___ |
| M. Do you have headache? | ___ | ___ |
| N. Do you have any discomfort in your jaw joints? | ___ | ___ |
| O. Are you teeth sensitive to hot, cold or sweets? | ___ | ___ |
| P. Do you have neck - aches? | ___ | ___ |
| Q. Clicking or popping jaws? | ___ | ___ |
| R. Tiredness in the jaw? | ___ | ___ |
| S. Ringing in your ears? | ___ | ___ |
| T. Are you bothered by a limited or reduced opening of the jaws? | ___ | ___ |
| U. Are you aware that you clench, grind or grit your teeth? | ___ | ___ |
| V. Do you have any difficulty or discomfort chewing? | ___ | ___ |
| W. Do your gums bleed when you brush? | ___ | ___ |
| X. Do you take food supplements? | ___ | ___ |
| Please list _____ | ___ | ___ |
| Y. Does food catch in between your teeth? | ___ | ___ |
| Z. Do you have sinus trouble? | ___ | ___ |
| AA. Are you a mouth breather? | ___ | ___ |
| AB. Do you have a tendency to have motion, car or air sickness? | ___ | ___ |
| AC. Did either of your parents lose all of their teeth? | ___ | ___ |

For office Use

Present Dental Complaints

Dental History Notes:

Medical History

DO YOU HAVE OR EVER HAD:	Yes	No		Yes	No
Hepatitis, jaundice or liver disease	___	___	Nitrous oxide sedation	___	___
Epilepsy, convulsions or fainting spells	___	___	AIDS	___	___
Rheumatic fever	___	___	AIDS antibody (HIV or HTLV)	___	___
Heart Valve problems	___	___	Anticoagulants (blood thinners)	___	___
Mitral valve problems	___	___	Blood Transfusion	___	___
Heart Murmur	___	___	Emotional problems or tension.	___	___
Heart trouble or stroke	___	___	Nervous breakdown, psychotherapy	___	___
Angina pectoris	___	___	Cortisone medication	___	___
High or low blood pressure	___	___	Prostate trouble	___	___
Heart pacemaker	___	___	Alcoholism	___	___
Shortness of breath	___	___	Drug Addiction	___	___
Chest pains	___	___	Eating disorder (anorexia, bulimia)	___	___
Artificial heart valve	___	___	Been hospitalized in the past 5 years	___	___
Swelling in the ankles	___	___	Any serious illness not listed...	___	___
Tuberculosis	___	___	ARE YOU:		
Kidney disease or infection	___	___	Taking aspirin daily	___	___
Diabetes	___	___	Presently under physicians care	___	___
A. Any blood relatives	___	___	Taking Vitamins	___	___
B. Do you urinate frequently	___	___	Allergic to dental anesthetic	___	___
C. Are you often thirsty	___	___	Aware of recent weight change	___	___
Arthritis	___	___	Often Exhausted or fatigued	___	___
Rheumatoid Arthritis	___	___	A nervous person	___	___
Artificial joint	___	___	Presently under unusual stress or emotional tension	___	___
Stomach or duodenal ulcers	___	___	Taking nerve or sleeping medication	___	___
Medical radiation (x-ray) treatment for other than diagnosis	___	___	Often unhappy or depressed	___	___
Glaucoma	___	___	Taking antidepressant medication	___	___
Asthma, hay fever or allergies	___	___	Do you bruise easily	___	___
Drug reaction to codeine, tetracycline, penicillin, Demerol	___	___	Do you wear contact lenses	___	___
Valium, erythromycin, percocet, nitrous oxide, novocaine ,	___	___			
Barbiturates, aspirin, other _____	___	___	If you smoke, how much	___	___
Arteriosclerosis	___	___			
Thyroid or parathyroid disease	___	___			
Venereal disease	___	___			
Genital Herpes	___	___			
Surgery	___	___			
Hospitalization or illness	___	___			
Hives or skin rash	___	___			
Cancer or abnormal growth	___	___			
Anemia or blood disorder	___	___			
Abnormal bleeding problems	___	___			
Allergic to Penicillin	___	___			
Allergic to any other medication	___	___			
List any other medications you are taking	___	___			

FOR FEMALE PATIENTS Only:

Patient Consent Form for Pre Meds:

I have been advised that certain antibiotic, aspirin products, antacids, and other medications commonly prescribed for dental conditions, may interfere with the reliability of oral contraceptives which may result in unwanted pregnancy. I have been advised that if on oral contraceptives, and I am prescribed medications during dental treatment, I should consult with my gynecologist or primary physician as to what other precautions I should employ to prevent an unwanted Pregnancy during any period of time that I am taking these medications.

Knowing these risks, I consent to the pre meds prescribed by Dr Jepsen or Dr Murphy.

Signature

Medical History Notes:

- II. I give my consent to use local anesthetics, relaxants, nitrous oxide or a combination for completing any necessary dental treatment. I also do _____ do not _____ grant permission to take photographs of my mouth to be used, without revealing my identity, for the furthering of dental knowledge and education.**

Signature

FAMILY INFORMATION RECORD

DATE _____

NAME RESPONSIBILITY PARTY _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ SEX _____ DATE OF BIRTH _____
NUMBER OF DEPENDANTS _____ SOCIAL SECURITY NUMBER _____
EMPLOYER'S NAME _____ BUSINESS PHONE _____
EMPLOYER'S ADDRESS _____
CITY _____ STATE _____ ZIP _____

NAME OF SPOUSE _____ SEX _____ DATE OF BIRTH _____
EMPLOYER'S NAME _____ BUSINESS PHONE _____
EMPLOYER'S ADDRESS _____ SSN _____
CITY _____ STATE _____ ZIP _____

DEPENDANT CHILDREN

NAME _____ SEX _____ DATE OF BIRTH _____
RELATIONSHIP TO RESPONSIBLE PARTY _____ SSN _____

NAME _____ SEX _____ DATE OF BIRTH _____
RELATIONSHIP TO RESPONSIBLE PARTY _____ SSN _____

NAME _____ SEX _____ DATE OF BIRTH _____
RELATIONSHIP TO RESPONSIBLE PARTY _____ SSN _____

NAME _____ SEX _____ DATE OF BIRTH _____
RELATIONSHIP TO RESPONSIBLE PARTY _____ SSN _____

NAME _____ SEX _____ DATE OF BIRTH _____
RELATIONSHIP TO RESPONSIBLE PARTY _____ SSN _____

IN CASE OF EMERGENCY

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____
ADDRESS _____ PHONE _____
CITY _____ STATE _____ ZIP _____

INSURANCE

PRIMARY INSURANCE

NAME OF DENTAL INSURANCE CARRIER _____

GROUP NAME _____ GROUP NUMBER _____

CARRIER ADDRESS _____

CITY _____ STATE _____ ZIP _____

LOCATION OR LOCAL UNION _____

SECONDARY INSURANCE

NAME OF DENTAL INSURANCE CARRIER _____

GROUP NAME _____

CARRIER ADDRESS _____

CITY _____ STATE _____ ZIP _____

LOCATION OR LOCAL UNION _____

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR MY DEPENDANTS. I FURTHER EXPRESSLY AFREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY DENTIST TO SUBMIT CLAIMS FOR BENEFITS, FOR SERIVCES RENDERED OR TO BE RENDERED WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDANTS AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

AUTHORIZED SIGNATURE OF COVERED PERSON/EMPLOYEE

DATE

OUR OFFICE WILL PROCESS INSURANCE FORMS AS A COURTESY TO YOU. WE ASSUME NO RESPONSIBILITY FOR GUARANTEEING PAYMENT BY THE INSURANCE COMPANY AND ANY DISPUTE AS TO COVERAGE IS BETWEEN YOU AND THE INSURANCE COMPANY.

I HAVE READ, AND UNDERSTAND THE ABOVE POLICIES. I AM THE PERSON FINANCIALLY RESPONSIBLE FOR THE FEES.

SIGNATURE

DATE

OFFICE FINANCIAL POLICY

In order to provide more efficient financial services to our patients, and to minimize our administrative costs, we ask your cooperation with the following policy.

1. We will provide you a financial estimate of charges, insurance benefits, and your personal obligation prior to scheduling your dental treatment.
2. **We ask that you pay for your portion at the time the treatment is provided.** If you have insurance, we will estimate the amount to be covered by your insurance, and you can pay the difference. Once your insurance company pays, we will refund any excess, or bill you any shortfall. We accept cash, check, Mastercard, Visa, Discover in addition to Care Credit and Dental Fee Plan Financing as methods of payment. **In office payment plans are not acceptable methods of payment.**
3. We will file your dental insurance claims as a courtesy to you. Regardless of insurance coverage, you are ultimately responsible for the costs. All outstanding insurance claims over 120 days are due from the patient.
4. Please notify us of any change in your dental insurance benefits as soon as possible.
5. We will charge interest of 1.5% per month on accounts with past due balances.
6. If an account is referred to a collection agency you will be dismissed from the practice.

Patient Signature

Date