DENTAL REGISTRATION AND HISTORY

This information is necessary for our files and your health and will be considered CONFIDENTIAL

PATIENT INFORMATION

Patient Name ____________________ Date__________

Birthdate__________ S.S.#____________________ Male ☐ Female ☐

Residence Street Address ____________________

City ____________________ State__________ Zip Code __________

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employer ____________________

Employer Address ____________________

Spouse's Name ____________________

Spouse's Employer ____________________

Whom may we thank for referring you?____________________

PHONE NUMBERS

Home ( ) ____________________ Work ( )__________ Ext__________

Cell ( )__________ Spouse's Work __________ Email____________________

Best time and place to reach you ____________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name ____________________ Relationship __________

Home Phone ( )____________________ Work Phone ( )__________

DENTAL INSURANCE

No dental insurance ☐

Insurance Company Phone Number____________________ Group#__________

Subscriber's Name ____________________ Subscriber's SSN__________

Subscriber's Birthdate __________ Subscriber's Employer ____________________

Do you have additional dental insurance? Yes ☐ No ☐

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I or my dependent have insurance coverage and assign directly to Dr. Brad Justesen all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that all dental services furnished are charged directly to the patient, and that the patient is personally responsible for payment of all dental services. I understand the dental office will help to prepare the patient's insurance forms to assist in making collections from insurance companies and will credit any such collections to the patient's account. I also understand that this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

____________________ __________ __________

Responsible Party's Signature Relationship Date

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

DOB ____________________

☐ DENTAL HISTORY

Date of last dental visit____________________________ Date of last dental x-rays____________________________

Former Dentist __________________________________City/State____

Have you ever had any serious trouble associated with any previous dental procedure? Yes ☐ No ☐

If yes, please explain ____

Does dental treatment make you nervous? Yes ☐ No ☐ If yes, check: Slightly ☐ Moderately ☐ Extremely ☐

Have you ever had: orthodontic treatment? Yes ☐ No ☐ Periodontal (gum) treatment Yes ☐ No ☐

How often do you brush?__________________________ How often do you floss?____________________________

Do you have any problem with any of the following?

	Yes	No		Yes	No
Unfavorable reaction from dental anesthetic	☐	☐	Bad Breath	☐	☐
Swollen, tender, bleeding gums	☐	☐	Dry mouth/Mouth breather	☐	☐
Smoke or chew tobacco	☐	☐	Clicking or popping jaw	☐	☐
Food collection between the teeth	☐	☐	Grinding teeth	☐	☐
Sensitivity to hot, cold, sweets	☐	☐	Jaw pain or tiredness	☐	☐
Sensitivity to biting or pressure	☐	☐	Sores or growths in mouth	☐	☐
Loose teeth or broken fillings	☐	☐	Mouth pain with brushing	☐	☐

If there were something you would change about your smile, what would it be?__________________

☐ MEDICAL HISTORY

Physician's Name__________________________Phone Number _________________ Date of last visit___________

Are you under the care of a physician? Yes ☐ No ☐ If yes, what for ____________________________________

Have you ever had any serious illness or operation? Yes ☐ No ☐ If so, explain______________________________

Are you pregnant? Yes ☐ No ☐ How many months_________ Do you take birth control pills? Yes ☐ No ☐

Do you have, or have you had any of the following?

☐ Arthritis
☐ Anemia/Blood disorder
☐ Aneurism
☐ Artificial Joint
☐ Asthma
☐ Diabetes
☐ Epilepsy
☐ Fainting Spells
☐ Fosamax/Boniva/Biphosphonates
☐ Glaucoma
☐ HIV/AIDS
☐ Heart Murmur
☐ Rheumatic Fever
☐ Hepatitis A,B,C

☐ High Blood Pressure
☐ Kidney Problems
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Psychiatric Problems
☐ Radiation Therapy
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumor History
☐ Ulcers
☐ Venereal Disease
☐ Taken Fen-Phen

ALLERGIES

Yes ☐	No ☐	Aspirin
Yes ☐	No ☐	Codeine
Yes ☐	No ☐	Dental Anesthetics
Yes ☐	No ☐	Erythromycin
Yes ☐	No ☐	Jewelry
Yes ☐	No ☐	Latex
Yes ☐	No ☐	Metals
Yes ☐	No ☐	Penicillin
Yes ☐	No ☐	Tetracycline

OTHER:____________________________
____
____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

____

Pharmacy Name____Phone Number ______________________________

☐ CONSENT FOR TREATMENT/TERMS & CONDITIONS

I hereby grant authority to Dr. Brad Justesen to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such treatment as may be deemed necessary or advisable. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. If for any reason my unpaid balance exceeds 90 days I understand that a service charge of 1.5% (18% per annum) will be charged to my account. I further agree and understand that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable collection/attorney fees if a suit be instituted hereunder.

I have read the above consent for treatment and terms & conditions and agree to their content.

Signed ____ Date______________________

I______________________________ voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods- Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia has significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others.

I acknowledge that any insurance coverage or managed care benefits that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me.

Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $25 returned check fee. Any account balances that remain unpaid for 90 days from the date of service shall be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company lo make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Date: _________________________

Print Name: ____

Guardian/Responsible Party, if minor: ____

Signature: ____

First Impression Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, ____, have received a copy of this Office's Notice of Privacy Practices.

____
Signature

____
Date

May release and or discuss all information including appointment dates, treatment necessary and financial status to:

Name:____

⇩ For Office Use Only ⇩

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement count not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify)

____
____
____