



Dr. Joe Jeppson
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PATIENT INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Minor		Employer: Occupation:	SS#:
Home Phone:	Cell:	Work:	Email:
Person responsible for this account: Relationship:		Address:	
		City:	St: Zip:
Phone:		SS#:	DL#:
Emergency Contact:		Phone:	Relationship:
Has any member of your family ever been treated in our office? Yes <input type="checkbox"/> No <input type="checkbox"/> Name:			
Whom can we thank for referring you to us, or how did you discover our office?			

DENTAL INSURANCE

We bill insurance as a courtesy.
 If you would like us to help you submit to your insurance, please present your insurance card.

Insurance Company:	Insured's Name and ID Number:
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Assignment of Insurance Benefit: I hereby authorize my insurance benefits to be paid to Joe Jeppson DMD. I am responsible for services and balances not covered. I authorize the release of any dental/medical information necessary to process my claim or determine my treatment.

Financial Policy: Payment is due at time of service. If you are unable to pay in full, refer to OFFICE POLICIES- CREDIT OPTIONS.

DENTAL HISTORY

Reason for today's visit:		Date of last dental visit:	
Former Dentist:		Location:	Last x-rays:
How often do you brush?		How often do you floss?	
CHECK ALL THAT APPLY.	<input type="checkbox"/> Food collecting in between teeth	<input type="checkbox"/> Jaw pain or tiredness	<input type="checkbox"/> Snoring
<input type="checkbox"/> Sensitivity to COLD	<input type="checkbox"/> Gums swollen or tender	<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Tobacco use
<input type="checkbox"/> Sensitivity to HOT	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Sensitivity to SWEETS	<input type="checkbox"/> Blisters on lips or in mouth	<input type="checkbox"/> Bite guard appliance	<input type="checkbox"/> Abnormal bad breath
<input type="checkbox"/> Sensitivity to PRESSURE	<input type="checkbox"/> Sores or growths in mouth	<input type="checkbox"/> Pain around ear	<input type="checkbox"/> Burning sensation in tongue
<input type="checkbox"/> Broken Teeth or Fillings	<input type="checkbox"/> Past periodontal/gum treatment	<input type="checkbox"/> Headaches	<input type="checkbox"/> Oral piercings
<input type="checkbox"/> Throbbing pain	<input type="checkbox"/> Swelling	<input type="checkbox"/> Dental implants	<input type="checkbox"/> Orthodontic Retainer
<input type="checkbox"/> Dull, constant pain	<input type="checkbox"/> Gum recession	<input type="checkbox"/> Generally sensitive teeth	<input type="checkbox"/> Other: _____
Which of the following have you had in connection with your past dental experiences?			
<input type="checkbox"/> Excessive gag reflex	<input type="checkbox"/> Anxiety from injections	<input type="checkbox"/> Trouble getting numb	<input type="checkbox"/> Rapid heartbeat/dizziness
<input type="checkbox"/> Trouble with holding open	<input type="checkbox"/> Trouble staying numb	<input type="checkbox"/> Numb too long	<input type="checkbox"/> Sensitive fillings
<input type="checkbox"/> Difficulties from a small mouth	<input type="checkbox"/> Need for Anti-anxiety medication	<input type="checkbox"/> Other: _____	

HEALTH HISTORY

Physician:		Date of last visit:	
Mark all that apply.	<input type="checkbox"/> Recent surgery/illness	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Use of Fosamax, Zometa, Aredia, Actonel, or Boniva,	<input type="checkbox"/> Congenital Heart Lesions <input type="checkbox"/> Cortisone treatments	<input type="checkbox"/> Jaw pain <input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke <input type="checkbox"/> Swollen feet or ankles
<input type="checkbox"/> Use of fen-phen, or like drugs	<input type="checkbox"/> Cough, persistent or bloody	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Swollen neck glands
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Nervous problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Artificial heart valves	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tumor of head or neck
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Fainting or dizziness	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Asthma <input type="checkbox"/> Use an inhaler	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation treatment	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Back problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Respiratory disease	<input type="checkbox"/> Weight loss, unexplained
<input type="checkbox"/> Excessive bleeding episodes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic fever	OTHERS:
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Scarlet fever	
<input type="checkbox"/> Cancer, Type _____	<input type="checkbox"/> Hepatitis type ____	<input type="checkbox"/> Shortness of breath	
<input type="checkbox"/> Chemical/Drug dependency	<input type="checkbox"/> Herpes	<input type="checkbox"/> Sinus trouble	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin rash	
<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Special diet	

Women:	Pregnant <input type="checkbox"/> Due date _____	Nursing <input type="checkbox"/>
	Taking birth control <input type="checkbox"/> (NOTE: Taking antibiotics reduces efficacy of oral contraception.)	

MEDICATIONS

List any medications you are currently taking and the corresponding diagnosis:

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin	OTHERS:
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Latex	<input type="checkbox"/> Metals	
<input type="checkbox"/> Codeine	<input type="checkbox"/> Local anesthetic	<input type="checkbox"/> Sulfa	

SMILE INVENTORY

Is there anything you would like to change about your smile?

Have you had past cosmetic treatment? What?

CHECK ANY YOU WOULD LIKE MORE INFO ON:		<input type="checkbox"/> Bleaching (ZOOM! vs. trays)	<input type="checkbox"/> Porcelain veneers and crowns
<input type="checkbox"/> Laser Gum recontouring	<input type="checkbox"/> Cosmetic bonding	<input type="checkbox"/> Enamelplasty/Tooth Recontouring	<input type="checkbox"/> Tooth lengthening
<input type="checkbox"/> Dental Implants	<input type="checkbox"/> Replacing missing teeth	<input type="checkbox"/> Beautiful, functional dentures	<input type="checkbox"/> Internal bleaching

I hereby certify that the answers to the foregoing questions are accurate to the best of my knowledge. I accept the terms of Jeppson Dental's financial and office policies.

Signature _____ **Date** _____
Patient, parent, legal guardian or authorized agent of the patient



OFFICE POLICIES

APPOINTMENT POLICIES

Your appointment times are very important to us.

Several staff members are employed to ensure your visits to our office are time and cost efficient to us both. We confirm as a courtesy, but the ultimate responsibility is yours to keep your appointment.

1. Cancellation with less than *48 hours notice* will be subject to a **\$50 fee**.
2. Failure to keep an appointment will be subject to a **\$50 fee per hour missed**.
3. All accounts 60 Days past due are subject to a **\$25 one time service fee**.

Please Initial: _____

OFFICE FINANCIAL POLICY

I agree to pay in full at time of services, unless prior arrangements are made.

1. We accept cash, checks, Visa, MasterCard, and Discover Card. Credit card payments can be made over the phone.
2. We bill insurance as a service to you. **Your estimated portion is due at time of service.** A statement of any remaining balance will be sent to you, which balance is due in full by the 25th of the month.
3. I also agree to pay a finance charge of 1.75% per month on any balance carried over from the previous month.

Note: If your insurance sends your benefit checks to you (BC/BS), full payment is due at time of service.

Credit options:

I agree to arrange one of the below options prior to receiving treatment or to pay in full at the time of service.

1. 90 day in-office financing with automatic deductions to your credit card. See form.
2. CareCredit outside financing with a 12-month interest-free plan for charges over \$300 OAC. Application must be submitted and approved prior to treatment.

Collections: Any balance remaining 90 days after the date of service is subject to a collection fee (a minimum of 40% of the balance) to cover collection/court costs and fees. The account will be then turned over our collection agency and their attorney.

Please Initial: _____

PRIVACY POLICY

I have been given the opportunity to read and understand the privacy policies of this office. I understand that I can ask for any portion of the document to be explained to me before signing and **a copy of the privacy policies will be provided at my request.**

I hereby release the use of any **dental photographs** taken during the course of my treatment for the use of Jeppson Dental for patient education or practice promotion.

INFORMED CONSENT AND ASSIGNMENT OF BENEFITS

I have been informed of my treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with treatment claims. I also authorize direct payment of my dental benefits directly to Dr. Jeppson or Jeppson Dental.

I understand and agree to the above office policies.

Name (Please Print): _____ Signature: _____ Date: _____