Dr. Joe Jeppson
86 North University Avenue, Suite 280, Provo, UT 84601
Phone: (801) 356-7701 Fax: (801) 356-1877

PATIENT INFORMATION

Date:_____

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Address:	**City:**	**St:**	**Zip:**
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor	**SS#:**	Employer: Occupation:	
Home Phone:	**Cell:**	**Work:**	**Email:**
Person responsible for this account:		Address:	
Relationship:		City:	St: Zip:
Phone:		SS#:	
Emergency Contact:		Phone:	Relationship:
Has any member of your family ever been treated in our office? Yes ☐ No ☐ 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:	**Ins. Phone #:**	**Group #:**
Insured's Name:	**Date of birth:**	**ID #:**
Employer:		

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.	☐ Food collecting in between teeth	☐ Jaw pain or tiredness	☐ Snoring
☐ Sensitivity to COLD	☐ Gums swollen or tender	☐ Clicking or popping jaw	☐ Tobacco use
☐ Sensitivity to HOT	☐ Bleeding gums	☐ Grinding teeth	☐ Dry mouth
☐ Sensitivity to SWEETS	☐ Blisters on lips or in mouth	☐ Bite guard appliance	☐ Abnormal bad breath
☐ Sensitivity to PRESSURE	☐ Sores or growths in mouth	☐ Pain around ear	☐ Burning sensation in tongue
☐ Broken Teeth	☐ Past periodontal/gum treatment	☐ Headaches	☐ Oral piercings
☐ Broken Fillings	☐ Swelling	☐ Dental implants	☐ Orthodontic Retainer
☐ Pain	☐ Gum recession	☐ Generally sensitive teeth	☐ Other:_____
Which of the following have you had in connection with your past dental experiences?			
☐ Excessive gag reflex	☐ Anxiety from injections	☐ Trouble getting numb	☐ Rapid heartbeat/dizziness
☐ Trouble with holding open	☐ Trouble staying numb	☐ Numb too long	☐ Sensitive fillings
☐ Difficulties from a small mouth	☐ Need for Anti-anxiety medication	☐ Other:_____	

HEALTH HISTORY

Physician:		**Date of last visit:**	
Mark all that apply.	☐ Recent surgery/illness Describe:	☐ Lung problems	☐ Anxiety
☐ Osteoporosis ☐ Use of Fosamax, Zometa, Aredia, Actonel, or Boniva,		☐ Jaw pain	☐ Stroke
		☐ Kidney disease	☐ Swollen feet or ankles
☐ Use of Fen-Phen, or like drugs	☐ Cough, persistent or bloody	☐ Liver disease	☐ Swollen neck glands
☐ AIDS/HIV	☐ Cortisone treatments	☐ Low blood pressure	☐ Thyroid problems
☐ Anemia	☐ Diabetes	☐ Mitral valve prolapse	☐ Tonsillitis
☐ Arthritis, Rheumatism	☐ Emphysema	☐ Nervous problems	☐ Tuberculosis
☐ Artificial heart valves	☐ Epilepsy	☐ Pacemaker	☐ Tumor of head or neck
☐ Artificial joints	☐ Fainting or dizziness	☐ Psychiatric care	☐ Ulcer
☐ Asthma ☐ Use an inhaler	☐ Glaucoma	☐ Radiation treatment	☐ Venereal disease
☐ Back problems	☐ Headaches	☐ Respiratory disease	☐ Weight loss, unexplained
☐ Excessive bleeding episodes	☐ Heart Murmur	☐ Rheumatic fever	☐Tobacco use
☐ Blood disease	☐ Heart problems	☐ Scarlet fever	☐Drink coffee, tea, red wine or dark colas
☐ Cancer, Type_____	☐ Hepatitis type ___	☐ Shortness of breath	**OTHERS:**
☐ Chemical/Drug dependency	☐ Herpes	☐ Sinus trouble	
☐ Chemotherapy	☐ High blood pressure	☐ Skin rash	
☐ Circulation problems	☐ Jaundice	☐ Special diet	

Women:	Pregnant ☐ Due date_____ Nursing ☐ Taking birth control ☐ (NOTE: Taking antibiotics reduces efficacy of oral contraception.)

MEDICATIONS ☐None

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

ALLERGIES ☐None

☐ Aspirin	☐ Penicillin	☐ Barbiturates	☐ Metals	☐ Local anesthetic
☐ Iodine	☐ Latex	☐ Codeine	☐ Sulfa	**OTHERS:**

COSMETIC DENTISTRY (Mark to receive more information regarding any of the following.)

Teeth Whitening ☐	Straighter Teeth ☐	Veneers, Crowns, or Cosmetic Bonding ☐	**Free Consult** ☐

What changes would you make to your smile? _____

_____

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 ***2 Business Days*** *notice* will be subject to a **$50 fee** per every hour missed.
2. In the event of an emergency after regular business hours a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $125 after hours emergency fee.

Please Initial:_____

OFFICE FINANCIAL POLICY

Jeppson Dental does require payment in full for your portion at the time of service.
Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

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 courtesy to you. **Your estimated portion is due at time of service**.
3. A statement of any remaining balance after insurance will be sent to you, which the balance is due upon receipt.
4. 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.

5. There will be a $25.00 charge for all Returned checks due to Non Sufficient Funds.

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. Payment in full.
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. 3% administrative fee.
3. 90 day in-office financing with automatic monthly charges to your credit card. 5% administrative fee.

Collections: Any balance remaining 90 days after the date of service or financial agreement that is not followed is subject to a collection fee (a minimum of 34% 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:_____

CONSENT TO PROCEED

I authorize Dr. Jeppson and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health or any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with standard preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Print Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian, or authorized agent of patient)

Witness: _____ Date: _____