



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

PATIENT INFORMATION

Date: _____

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address:		City:	St: Zip:
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	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 <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:	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.	<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	<input type="checkbox"/> Past periodontal/gum treatment	<input type="checkbox"/> Headaches	<input type="checkbox"/> Oral piercings
<input type="checkbox"/> Broken Fillings	<input type="checkbox"/> Swelling	<input type="checkbox"/> Dental implants	<input type="checkbox"/> Orthodontic Retainer
<input type="checkbox"/> 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 Describe:	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Anxiety
		<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Stroke
<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Use of Fosamax, Zometa, Aredia, Actonel, or Boniva,		<input type="checkbox"/> Kidney disease	<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"/> Cortisone treatments	<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	<input type="checkbox"/> Tobacco use
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Drink coffee, tea, red wine or dark colas
<input type="checkbox"/> Cancer, Type _____	<input type="checkbox"/> Hepatitis type ____	<input type="checkbox"/> Shortness of breath	OTHERS:
<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 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

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

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

<input type="checkbox"/> Teeth Whitening	<input type="checkbox"/> Straighter Teeth	<input type="checkbox"/> Veneers, Crowns, or Cosmetic Bonding	Free Consult <input type="checkbox"/>
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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 **\$75 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. 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. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

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 of 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: _____