ERIC R. JENSEN, D.M.D.

Health Questionnaire

Name: ______________________ **Date:** __________
Birth date: __________ **SS#:** __________ **If minor, parent's name:** __________
Home address: ______________________ **City:** __________ **Zip code:** __________
Home phone: __________ **Cell phone:** __________ **Work phone:** __________
Email: ______________________ **Email / Text OK? Yes** ______ **No** ______
Employment: __________ **Referred by:** __________
Emergency contact name: __________ **phone:** __________
Reason for seeking treatment: ______________________
Physician's name: __________ **Phone:** __________ **Date of last physical exam:** __________

Are you currently in good health?	**Yes**	**No**	**Are you allergic to or have you ever reacted adversely to any of the following:**	**Yes**	**No**
Are you currently under medical care?			Penicillin		
If yes, for what?			Other antibiotics		
			Local anesthetics		
Any recent illness, surgery, or hospitalization?			Aspirin		
If yes, for what?			Codeine		
Have you ever had the following:			**Are you taking any of the following:**		
Artificial joints			Antibiotics		
Heart attack			Anticoagulants (blood thinners)		
Pacemaker			Blood pressure medications		
History of ineffective endocarditis			Cortisone or steroids		
Artificial heart valve			Tranquilizers		
Congenital heart disease			Anticonvulsants		
High blood pressure			Nitroglycerin		
Organ transplant (i.e. heart, kidney, etc.)			Other:		
Stroke					
Seizures or epilepsy			**Women:**		
Diabetes			Are you or could you be pregnant?		
Hepatitis			Are you nursing?		
HIV/AIDS			Are you taking birth control medications?		
Liver disease					
Kidney disease			**Is there anything you would like to change about your smile?**		
Thyroid					
Surgery, radiation, or chemotherapy for a tumor or growth?			If yes, please explain:		
Prolonged bleeding associated with previous surgery, extraction, or accident					
Required a blood transfusion			**Have you ever had the following:**		
Anemia or other blood disorder			Gums bleed when you brush or floss		
Chest pain upon exertion			Grinding or clenching your teeth		
Shortness of breath after mild exercise			Often occurring toothaches		
History of smoking / vaping / tobacco use			Injuries to your mouth or jaws		
Asthma			Mouth or jaw sores, ulcers, or swellings		
Emphysema / COPD			Complications with previous dental care		
Tuberculosis			Are you satisfied with previous dental care?		
Persistent cough or coughing up blood			If not, please explain:		
Arthritis					
Osteoporosis / osteopenia					

Please list any medications you are currently taking or provide a list.

Drug	Purpose	Drug	Purpose
__________	__________	__________	__________
__________	__________	__________	__________

Signature: ______________________ **Date:** __________

Jensen Family Dentistry
Eric R Jensen, DMD

ALL PATIENTS READ AND SIGN

Payment is due at the time services are rendered. We accept cash, credit cards, checks and Care Credit.

If you receive a billing statement from Jensen Family Dentistry, it is due upon receipt. Statements not paid in a timely manner may be sent to collections.

Missed appointments: There is a minimum charge of $25 for missed/cancelled appointments without 24-hours advance notice. A larger fee may apply if the scheduled appointment time exceeds one hour.

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Patient or Guardian Signature and Date

DENTAL BENEFITS

Listed below are the dental insurance plans that Dr. Jensen is contracted with. If you have a plan not shown below, and it is a PPO that will allow you to see a provider of your choice, we will file for you as an out-of-network provider.

*BCBS Federal *Florida Combined Life PPO *Guardian PPO *Sun Financial PPO

Please provide your dental insurance information, if applicable.

Dental Carrier Name and Address: ____
Carrier Phone Number: ____
Employer: ____
Subscriber Name and DOB: ____
SSN/ID No: ____
Group No: ____

Please present your dental benefits card to the receptionist. If you do not have a card, you will need to provide all necessary information. If you do not have all the information needed to file your claim or verify your coverage, you will be responsible for all charges in full at the time of service. Eligibility is not a guarantee of coverage, as actual benefit payments are determined only when a claim is processed. Any unpaid balance remaining will be your responsibility. Please advise us of any services rendered previously at another office that may affect your coverage here due to time limitations. Knowing your coverage, including waiting periods, and tracking your yearly deductibles and maximum, is your responsibility.

INSURANCE WILL BE FILED AS A COURTESY
If no payment is received from your insurance company within 30 days, it becomes your responsibility. We will not accept their excuses such as the dental office never filed, claim was not received or they were waiting on information. **You, the patient, are responsible for all charges and should follow up on all claims.** Please request a predetermination for any treatment over $200 if you are unsure of your coverage.

In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance. If co-pays are not paid on a timely basis, payment in full will be expected at future visits regardless of your insurance status. Please note verification of coverage is not a guarantee of coverage, as insurance companies frequently misquote benefits. You are ultimately responsible for your account and knowing your policy's terms.

VERY IMPORTANT
Treatment is determined by necessity, not by what your dental benefits will cover. We are here to provide you with the best dental care, and our obligation is to our patients, not the insurance companies. Patients must understand their dental plan is a contract between themselves, their employer, and the insurance carrier. The dentist has no power over their plan and coverage.

I authorize the release of any information necessary for processing my claims. I have read and understand the above information.

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Patient or Guardian Signature and Date