DDS

The Art & Science of Dentistry

11–105th AVE SE
BELLEVUE, WA 98004
(425)454–7690
FAX (425)454–2172
JENSENBROWNDDS.COM

OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, American Express, personal check, money order, or registered check.

Insurance benefits are determined by your employer and not your dentist. **Any deductible or estimated co-payment amount will be due at the time of treatment.** Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your insurer. **Your insurance and payment are still your responsibility**. Upon your request, we would be happy to submit a pre-determination to your insurance company prior to your treatment in addition to the cost estimate you will receive from our office. As a courtesy we will be glad to file your claim for you if you bring 1) your dental insurance wallet card and 2) all required employer information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. **If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.**

We reserve the right to charge and collect fees for broken appointments – appointments that are cancelled or broken without 24-hours advance notice will receive a $75 fee. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned Check Fee of $40 will be added to your account balance and is collectible.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

Courtesies cannot be combined and are not to exceed 5%.

I have read and understand this financial policy.

______________________________ ______________________________

PRINTED NAME SIGNATURE

____

DATE

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ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Howard P. Jensen and Kevin M. Brown. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Howard P. Jensen and Kevin M. Brown reserve the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY ( ) YES ( ) NO
SPOUSE ONLY ( ) YES ( ) NO
OTHER (PLEASE SPECIFY)____________________________ ( ) YES ( ) NO

____
Name of Patient or Personal Representative

____
Signature of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

PROVIDED PRIOR TO TREATMENT ( ) YES ( ) NO

DATE PROVIDED:______________________

REASON FOR DENIAL:

- ❑ NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES
- ❑ WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING
- ❑ UNABLE TO SIGN
- ❑ REASON NOT GIVEN
- ❑ OTHER (EXPLAIN)____

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MEDICAL HISTORY

PATIENT NAME ____ Birth Date __________________________________

Are you under a physician's care now? □Yes □No If yes, please explain: ____
Have you ever been hospitalized or had a major operation? □Yes □No If yes, please explain: ____
Have you ever had a serious head or neck injury? □Yes □No If yes, please explain: ____
Are you taking any medications, pills, or drugs? □Yes □No If yes, please explain: ____
Do you take, or have you taken, Phen-Fen or Redux? □Yes □No ____
Have you ever taken Fosamax, Boniva, Actonel or any ____
other medications containing bisphosphonates? □Yes □No If yes, please explain: ____
Are you on a special diet? □Yes □No
Do you use tobacco? □Yes □No
Do you use controlled substances? □Yes □No

Women: Are you Pregnant/Trying to get pregnant? □ Yes □ No Taking oral contraceptives? □ Yes □ No Nursing? □Yes □ No
Are you allergic to any of the following?

☐Aspirin □Penicillin □Codeine □Acrylic □Metal □Latex □Local Anesthetics □Sulfa

Other If yes, please explain:____

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

AIDS/HIV Positive	□Yes	□No	Cortisone Medicine	□Yes	□No	Hemophilia	□Yes	□No	Radiation Treatments	□Yes	□No
Alzheimer's Disease	□Yes	□No	Diabetes	□Yes	□No	Hepatitis A	□Yes	□No	Recent Weight Loss	□Yes	□No
Anaphylaxis	□Yes	□No	Drug Addiction	□Yes	□No	Hepatitis B or C	□Yes	□No	Renal Dialysis	□Yes	□No
Anemia	□Yes	□No	Easily Winded	□Yes	□No	Herpes	□Yes	□No	Rheumatic Fever	□Yes	□No
Angina	□Yes	□No	Emphysema	□Yes	□No	High Blood Pressure	□Yes	□No	Rheumatism	□Yes	□No
Arthritis/Gout	□Yes	□No	Epilepsy or Seizures	□Yes	□No	High Cholesterol	□Yes	□No	Scarlet Fever	□Yes	□No
Artificial Heart Valve	□Yes	□No	Excessive Bleeding	□Yes	□No	Hives or Rash	□Yes	□No	Shingles	□Yes	□No
Artificial Joint	□Yes	□No	Excessive Thirst	□Yes	□No	Hypoglycemia	□Yes	□No	Sickle Cell Disease	□Yes	□No
Asthma	□Yes	□No	Fainting Spells/Dizziness	□Yes	□No	Irregular Heartbeat	□Yes	□No	Sinus Trouble	□Yes	□No
Blood Disease	□Yes	□No	Frequent Cough	□Yes	□No	Kidney Problems	□Yes	□No	Spina Bifida	□Yes	□No
Blood Transfusion	□Yes	□No	Frequent Diarrhea	□Yes	□No	Leukemia	□Yes	□No	Stomach/Intestinal Disease	□Yes	□No
Breathing Problem	□Yes	□No	Frequent Headaches	□Yes	□No	Liver Disease	□Yes	□No	Stroke	□Yes	□No
Bruise Easily	□Yes	□No	Genital Herpes	□Yes	□No	Low Blood Pressure	□Yes	□No	Swelling of Limbs	□Yes	□No
Cancer	□Yes	□No	Glaucoma	□Yes	□No	Lung Disease	□Yes	□No	Thyroid Disease	□Yes	□No
Chemotherapy	□Yes	□No	Hay Fever	□Yes	□No	Mitral Valve Prolapse	□Yes	□No	Tonsilitis	□Yes	□No
Chest Pains	□Yes	□No	Heart Attack/Failure	□Yes	□No	Osteoporosis	□Yes	□No	Tuberculosis	□Yes	□No
Cold Sores/Fever Blisters	□Yes	□No	Heart Murmur	□Yes	□No	Pain in Jaw Joints	□Yes	□No	Tumors or Growths	□Yes	□No
Congenital Heart Disorder	□Yes	□No	Heart Pace Maker	□Yes	□No	Parathyroid Disease	□Yes	□No	Ulcers	□Yes	□No
Convulsions	□Yes	□No	Heart Trouble/Disease	□Yes	□No	Psychiatric Care	□Yes	□No	Venereal Disease	□Yes	□No
									Yellow Jaundice	□Yes	□No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ______________________________________

Comments:____
____

Do we have your permission to use email to confirm your appointments? □Yes □ No
If yes, please provide:____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ DATE ____________________

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PATIENT INFORMATION		
DATE	SS#	BIRTHDATE
NAME		
LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE
EMAIL ADDRESS		
SEX: ☐ M ☐ F ☐	SINGLE ☐	MARRIED ☐
EMPLOYER	BUSINESS PHONE	
BUSINESS ADDRESS	OCCUPATION	
WHO SHOULD WE THANK FOR REFERRING YOU?		
EMERGENCY CONTACT	PHONE	
PRIMARY INSURANCE		
RESPONSIBLE PARTY		
LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	BIRTHDATE	SS#
ADDRESS	HOME PHONE	
CITY	STATE	ZIP
RESPONSIBLE PARTY EMPLOYER	BUSINESS PHONE	
BUSINESS ADDRESS	OCCUPATION	
INSURANCE COMPANY		
INSURANCE COMPANY ADDRESS		
SUBSCRIBER ID#	GROUP#	
ADDITIONAL INSURANCE		
INSURED NAME		
LAST NAME	FIRST NAME	MIDDLE INITIAL
RELATIONSHIP TO PATIENT	BIRTHDATE	SS#
ADDRESS	HOME PHONE	
CITY	STATE	ZIP
INSURED EMPLOYED BY	BUSINESS PHONE	
BUSINESS ADDRESS	OCCUPATION	
INSURANCE COMPANY		
INSURANCE COMPANY ADDRESS		
SUBSCRIBER ID#	GROUP#	

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MEDICAL RECORD RELEASE

DATE:________________________________

Please release my dental records and send them to the office of Dr. Howard P. Jensen, Dr. Kevin M. Brown and Dr. Brian M. Fong to the address listed above or email to FRONTDESK@JENSENBROWNDDS.COM

PATIENT NAME: ____

ADDRESS: ____

TELEPHONE#:____

Other family members for which transfer is requested:

____

____

____

____

SIGNATURE DATE

JENSEN BROWN | DDS
The Art & Science of Dentistry

Digital Photography Informed Consent

I, ______________________________, a patient of Dr. Howard Jensen and/or Dr. Kevin Brown have consented to digital photography. I understand that photographs may be taken during my dental procedures to enhance laboratory communication and the final result of my treatment. I also give my consent for Drs. Jensen and Brown to use photographs of my treatment for teaching and educational purposes. They may also use them in the office photo albums, website and/or social media. No names will be used when showing the photos.

______________________________ ______________________

Signature of patient or personal representative: Date: