JENSEN PEDIATRIC DENTISTRY
Regina Jensen, DDS, PA

Today's Date: _____/_____/_____

Who is accompanying your child today: _____ Relationship to child: _____

Do you have legal custody of this child? □ YES □ NO

Child's Information

Name: _____

□ Male □ Female Age: _____

Birthdate: ___/____/_____ SSN: _____-____-_____

Home address: _____

_____

Child's hobbies/interests: _____

_____

Other family members we treat: _____

_____

How did you hear about our office? _____

_____

Primary Dental Insurance Information

Policy owner's name:_____

Relationship to child: _____

Policy owner's employer:_____

Insurance name: _____

Insurance phone number: _____

Insurance address: _____

_____

Subscriber ID (SSN) # _____

Group number:_____

Parent/Legal Guardian Information:

Parent #1: _____

□ Mother □ Stepmother □ Guardian

Date of birth: ___/____/_____ SSN: _____-____-_____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Work Phone: _____

Parent #2: _____

□ Father □ Stepfather □ Guardian

Date of birth: ___/____/_____ SSN: _____-____-_____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Work Phone: _____

CHILD'S HEALTH HISTORY

YES NO Is your child adopted?

YES NO Is your child currently taking any medication? If yes, please list: _____

YES NO Is your child allergic to any medications? If yes, please list: _____

YES NO Is your child allergic to latex products?

YES NO Is your child currently under the care of a physician? (other than routine well checks)

YES NO Have you ever been told your child needs premedication for a heart condition before dental treatment?

YES NO Are you child's immunizations up to date?

Has your child ***ever*** had any of the following?:

Y	N	Abnormal bleeding	Y	N	Cystic Fibrosis	Y	N	HIV/AIDS
Y	N	ADD	Y	N	Developmental delay	Y	N	Hospitalization or surgery
Y	N	ADHD	Y	N	Diabetes	Y	N	Kidney/bladder problems
Y	N	Anemia	Y	N	Disability/Special Needs	Y	N	Liver Problems
Y	N	Asthma or lung condition	Y	N	Ear Infections	Y	N	Mental delay
Y	N	Autism	Y	N	Emotional/behavioral disorder	Y	N	Pregnancy
Y	N	Brain Injury	Y	N	Eye problems	Y	N	Rheumatic/scarlet fever
Y	N	Cancer	Y	N	Hearing loss or impairment	Y	N	Seasonal Allergies
Y	N	Cerebral palsy	Y	N	Heart disease/defect	Y	N	Sickle Cell Anemia
Y	N	Cleft lip and/or palate	Y	N	Heart murmur	Y	N	Spina Bifida
Y	N	Congenital birth defect	Y	N	Hemophilia/any blood disorder	Y	N	Tuberculosis
Y	N	Convulsions or seizures	Y	N	Hepatitis	Y	N	Thyroid problems

Please explain any YES responses: _____

_____

DENTAL HISTORY

YES NO Is this your child's first time to the dentist? If no, please list approximate last visit: _____

Name of previous dentist: _____ City, State: _____

Were x-rays taken? □ YES □ NO

Reason for today's visit: _____ Is your child in pain: □ YES □ NO

Does/did your child suck: □ Thumb □ Finger □ Pacifier Age discontinued: _____

Is/was your child: □ Breast-fed □ Bottle-fed Age discontinued: _____

What is your water source? □ Public/City □ Private/Well □ Mostly Bottled □ Reverse Osmosis System

I □ *always* □ *sometimes* □ *never* supervise my child's brushing

Toothbrushing is done ____ times a day

Flossing is done □ *always* □ *sometimes* □ *never*

Has your child ever been seen by an orthodontist? □ YES □ NO Name: _____

SCREENING DURING COVID-19 ERA

Please take your's and your child(ren)'s temperature at home prior to your appointment and only come in if it is below 100.3 F. Please expect for your's and your child(ren)'s temperature to also be taken at their visit upon arrival.

Please fill out the following COVID-19 prescreening on the morning of your child's appointment and bring with you to the appointment. If you or your child has experienced any of the following symptoms, please notify our office prior to your appointment. We will discuss your health status, the dental treatment your child needs, and whether or not visiting our office will be safe for you, your child, our other patients, and our staff.

Child's Name: _____

Has your child or the guardian accompanying your child to the appointment had any of the following in the last 14 days:	Child	Guardian
Fever (greater than 100.3)?	□ YES □ NO	□ YES □ NO
Shortness of breath or other difficulties breathing?	□ YES □ NO	□ YES □ NO
Cough?	□ YES □ NO	□ YES □ NO
Any other flu-like symptoms, such as chills, muscle pain, headache, fatigue?	□ YES □ NO	□ YES □ NO
Experienced recent loss of taste or smell?	□ YES □ NO	□ YES □ NO
Sore throat?	□ YES □ NO	□ YES □ NO
Nausea, vomiting or diarrhea?	□ YES □ NO	□ YES □ NO
In contact with any confirmed or suspected COVID-19 positive patients?	□ YES □ NO	□ YES □ NO

Thank you for your continued trust in Jensen Pediatric Dentistry. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so. As with the transmission of any communicable disease like a cold or flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place.

Despite our careful attention to sterilization, disinfection, social distancing, and use of personal barriers, there is still a chance you could be exposed to an illness in our office, just as you might be in any public place. Due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, dental team and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment? □ YES □ NO

Signature: _____ Date:_____

JENSEN PEDIATRIC DENTISTRY
X-RAY CONSENT

Radiographic or x-ray examinations provide your dentist with an important tool that shows the condition of your child's teeth, its roots, jaw placement and the overall composition of facial bones. X-rays allow the dentist to diagnose and treat conditions that cannot be detected during a clinical examination. Dental x-rays detect much more than cavities. For example, x-rays may be needed to survey erupting teeth or missing teeth, diagnose bone diseases, evaluate the results of an injury, or plan orthodontic treatment.

Do all patients have x-rays taken every six months?
No. Your child's radiographic schedule is based on the dentist's assessment. In most cases, new patients require a full mouth set of x-rays to evaluate oral health status, including any incipient lesions and for future comparison. Established patients may require x-rays every six months to monitor incipient lesions.

What kind of x-rays does the dentist usually take?
Typically, most patients have "periapical" or "bitewing" radiographs taken. Bitewing x-rays typically determine the presence of decay in between teeth, while periapical x-rays show root structure, bone levels, cysts, and abscesses.

My dentist has prescribed a "panoramic radiograph". What is that?
A panoramic radiograph allows the dentist to see the entire structure of your child's mouth in a single image. This x-ray reveals all of the upper and lower teeth and parts of the jaw. It will also show any abnormal growths, cysts and tumors. It is also used to evaluate for impacted or missing teeth.

Why does my child need both types of x-rays?
What is apparent through one type of x-ray often is not visible on another. The panoramic x-ray will give the dentist a general and comprehensive view of your child's entire mouth on a single film, which a periapical or bitewing x-ray cannot show.

Should I be concerned about exposure to radiation?
All healthcare providers are sensitive to patients' concern about exposure to radiation. Your dentist has been trained to prescribe radiographs when they are appropriate and to tailor radiographic schedules to each patient's individual needs. By using state-of-the-art technology your dentist knows which techniques, procedures and x-ray films can minimize your child's exposure to radiation.

Child's Name: _____ Date: _____

I **accep**t the recommended x-ray procedures:

Signature: _____

If you choose to wait on x-rays in our office it is with the understanding that it is in direct opposition to Dr. Jensen's recommendations. In some cases, she may ask you to seek services at an office that would agree to treat your child without radiographic examination.

I **decline** recommended x-rays procedures:

Signature: _____

OFFICE FINANCIAL POLICY
Dr. Regina Jensen, DDS. PA

If you have dental insurance, we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. Your insurance is a contract between you, your employer, and the insurance company. We are no part of the contract; however, we will do what is legally allowed to help you attain your benefits.

We are not responsible for how your insurance company hands its claims or for what benefits they pay on a claim. We can only assist you on estimating your position of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. Payment for services is due at the time services are rendered unless otherwise discussed with our office.

Many consumers think that their insurance pays 90% to 100% of dental fees. In reality most plans pay 50% to 80% of the total fee. How much your insurance pays is controlled by your employer, not our office. Our fees fall within that acceptable range by most insurance companies, however many insurance companies reimburse their policyholders based on a fee schedule which has not relationship to the current standard of care.

It is always our intention to do what is best for your child regardless of your insurance coverage. Please feel free to discuss any questions or concerns you may have with us. We appreciate your understanding in this matter.

I have read and agree to the terms and conditions of Dr. Regina Jensen's Financial Policy.

Signature: _____ Date: _____

Print Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
Dr. Regina Jensen, DDS, PA

You may refuse to sign this acknowledgement

Please review the following page titled "Notice of Privacy Practices" to learn how we maintain privacy of your health information. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

I have read and received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare; but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.