



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) _____



MEDICAL HISTORY

PATIENT NAME _____

Birth Date _____

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant?
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, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pace Maker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

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?
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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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 Bridgit@bellevuefamilydental.com

PATIENT NAME: _____

ADDRESS: _____

TELEPHONE#: _____

Other family members for which transfer is requested:

SIGNATURE

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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>		SINGLE <input type="checkbox"/>	MARRIED <input type="checkbox"/>
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#	