



Patient Information
(Confidential)

Date _____ Soc. Sec. # _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email Address _____ Cell Phone _____

Minor Single Married Divorced Widowed Separated

Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
If Patient is Student, Name of School/College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency? _____

Responsible Party

Person Responsible for Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Driver's Lic. # _____ Birthdate _____ Email Address _____
Employer _____ Work Phone _____

Is this Person currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____
Employer _____ Work Phone _____
Insurance Company _____ Group # _____ ID # _____
Ins. Mailing Address _____ City _____ State _____ Zip _____

Do You Have Additional Insurance? If Yes, Please Complete The Following:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____
Employer _____ Work Phone _____
Insurance Company _____ Group # _____ ID # _____
Ins. Mailing Address _____ City _____ State _____ Zip _____

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I understand that each appointment I will have is set-aside specifically for me. If I am more than 10 minutes late I may not be seen. If I fail to notify Dr. Jennings' staff more than 24 hours ahead of time of canceling an appointment or do not arrive for an appointment, a broken appointment fee of \$28.00 may be assessed.
5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. It is my responsibility to know my insurance benefits and plan parameters, and I will be responsible for telephoning them myself, should I have any questions. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed upon, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient Signature

Date

Parent or Responsible Party

Relationship to Patient

Thomas S. Jennings
2430 Research Pkwy Suite 200
Colorado Springs, CO 80920
719-590-7100

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices for the office of Thomas S. Jennings, DDS. 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.

Thomas S. Jennings, DDS reserves 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	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
SPOUSE ONLY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
INSURANCE COMPANY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

Patient Name

Signature

Date

Relationship



Patient Name _____

What is the reason for your visit today? _____

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit? _____

Previous Dentist's name? _____ Reason for leaving? _____

Address _____ City _____ State _____ Phone _____

How often do you have dental examinations? _____ How often do you brush? _____

What other dental aids do you use (Interplak, toothpick, etc.) _____ How often do you floss? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold? Yes No
 Sweets? Yes No
 Biting or Chewing? Yes No
 Have you noticed any mouth odors or bad tastes? Yes No
 Do you frequently get cold sores, blisters or
 any other lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease
 or tooth loss? Yes No
 Have you noticed any loose teeth or change
 in your bite? Yes No
 Does food tend to become caught in between
 your teeth? Yes No

If yes, where? _____

Do You:

Clench or grind your teeth while awake or sleep? Yes No
 Bite your lips or cheeks regularly? Yes No
 Hold foreign objects with your teeth?
 (pencils, pipe, pins, nails, fingernails) Yes No
 Mouth breathe while awake or asleep? Yes No
 Have tired jaws, especially in the morning? Yes No
 Smoke/Chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No
 Oral Surgery? Yes No
 Periodontal treatment? Yes No
 Your teeth ground or the bite adjusted? Yes No
 A bite plate or mouth guard? Yes No
 A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No
 Pain? (joint, ear, side of face) Yes No
 Difficulty in opening or closing the mouth? Yes No
 Difficulty in chewing on either side of the mouth? Yes No
 Headaches, neck aches or shoulder aches? Yes No
 Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth your whole life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe: _____

Patient Medical History

Patient's Name: _____

Physicians Name: _____

Physicians Phone Number: _____

If Female please answer the following:

Gender
 Male
 Female

Y N
 Are you taking Birth Control Pills?
 Are You Pregnant? # of weeks?
 Are you nursing?

Y N
 Do you smoke or use tobacco?

Height
 Weight

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Current Medical Treatment
<input type="checkbox"/>	<input type="checkbox"/>	History of Hospital Admissions
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Disease
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/ Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Fainting/ Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Unusual Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Family History of Diabetes

Please Explain All "Y" Answers In "Notes" Section Below.

Y	N	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline

Medications:

Y N Is there any disease, condition, or problem that you think this office should know about that is not covered above?
 If yes, please describe below

Notes:

GUIDELINES FOR PARENTS

IN TREATMENT AREAS

Dear Parents:

You may choose whether or not to accompany your child to the treatment area for his/her appointment. **However, we sense that most children do better without parents being present and respectfully make that recommendation to you.** Our goal is not only to provide your child with state of the art dental care, but to help them build the skills necessary to develop a positive relationship with professional health care providers. Our ability to help children in this way is almost always minimized by parents' presence.

We ask that siblings remain in the reception area for the duration of the appointment. If siblings are not mature enough to occupy themselves in the reception area with minimal supervision, please remain with them so we can proceed with your child's treatment without interruption.

If you choose to be present, we suggest the following guidelines to improve the chances of a positive outcome:

1. Allow us to prepare your child.
2. Be supportive of the practice's positive attitude and terminology.
 1. We don't use "needles" or "shots", we use "sleepy juice so your tooth can't feel anything."
 2. We don't "drill" teeth; we "scrub" them.
 3. We don't "pull" or "yank" teeth; we "wiggle" them.
 4. "Be brave" is not a useful phrase. This implies that there is something to fear, and this is not the message we want to send. Please encourage them to "be a good helper."
3. **Please be a silent observer**

1. This allows us to maintain communication with your child.
2. 3-way communication is ineffective, confusing for your child, and prevents us from developing a positive relationship with them.
3. You may give incorrect or misleading information
4. If asked to leave, be ready to immediately walk away.
 1. “Acting out” is normal, but not acceptable during treatment.
 2. Many children will try to control the situation by exhibiting uncooperative behavior.
 3. We will not restrain your child.
 4. We will continue to support your child at all times

These are very important ways that you can actively help in the success of your child’s visit. We are confident that all will go well and hope that these guidelines will help prepare you with confidence for the upcoming appointment. If you have any concerns or questions about this policy, please notify our office before your child’s appointment.

Sincerely,

Dr. Jennings and Staff