Todd Jorgenson, D.M.D., M.S.
Practice Limited to Periodontics

3048 E Baseline Rd. Ste. 112
Mesa, Arizona 85234
Telephone: 480-558-4500
Fax: 480-827-9703

PATIENT INFORMATION Today's Date _____

Name _____

Social Security # _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell / Mobile _____

Would you like to be contacted via email? Yes ◯ No ◯ Email Address _____

Please check one: Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

If Minor, Name of Parent / Guardian _____

Patient's / Parent's or Guardian's Employer _____

Business Address _____ City _____ State _____ Zip _____

Work Phone _____ Fax Number _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Work Phone _____ Spouse's Cell / Mobile _____

Person to Contact in Case of Emergency _____ Phone _____

Name of Referring Dentist _____ Phone _____

RESPONSIBLE PARTY

Name of Responsible Party for this Account _____

Relationship to Patient _____ Social Security # _____

Date of Birth _____ Driver's License _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell / Mobile _____

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

METHOD OF PAYMENT

For your convenience, we offer the following methods of payment. Payment is due, in full, on the day of treatment. A detailed description of the payment methods is attached and must be signed.

INSURANCE INFORMATION

Name of Insured_____

Relationship to Patient _____ Social Security # _____

Date of Birth _____ Driver's License _____

Name of Employer _____ Union / Local # _____

Employer's Address _____ City _____ State _____ Zip _____

Work Phone _____ Fax Number _____

Insurance Company _____ Group # _____ Policy # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Insurance Company Phone _____ Insurance Company Fax Number _____

How Much is the Deductible? _____ Max Annual Benefit _____ Amount Left _____

Do you have Additional Insurance? Yes ☐ No ☐ If yes, please fill out the following:

SECONDARY INSURANCE

Name of Insured_____

Relationship to Patient _____ Social Security # _____

Date of Birth _____ Driver's License _____

Name of Employer _____ Union / Local # _____

Employer's Address _____ City _____ State _____ Zip _____

Work Phone _____ Fax Number _____

Insurance Company _____ Group # _____ Policy # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Insurance Company Phone _____ Insurance Company Fax Number _____

How Much is the Deductible? _____ Max Annual Benefit _____ Amount Left _____

To the best of my knowledge, the information I have provided on this form is accurate. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the dentist the funds otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

Todd Jorgenson, D.M.D., M.S.

MEDICAL HISTORY

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No Please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No Please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No Please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No Please list: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Are you on a special diet? ◯ Yes ◯ No Do you use controlled substances? ◯ Yes ◯ No ◯ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No Please explain: _____

Comments: _____

_____

_____

*Condition may require medication N/A - Not answered by patient

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

East Valley Implant & Periodontal Center
Todd Jorgenson, D.M.D., M.S.

3048 E. Baseline Dr., Suite 112, Mesa, Arizona 85204
Phone: 480.558.4500 Fax: 480.827.9703

METHOD OF PAYMENT AGREEMENT

Please take note that you are solely responsible for your account, not your insurance carrier nor any other third party.

As a courtesy to our patients, we offer several methods of payment. For your convenience, we:

- bill your dental insurance on your behalf
- accept cash, personal check, Visa, MasterCard, Discover, and American Express
- offer dental treatment financing through HealthCare Finance (see staff members for details)
- offer all Senior Citizens (age 65 and older) a 5% discount

It is the office policy that payment is due, in full, at the time of treatment.

When billing dental insurance, we request that a deposit of 25% of your *estimated* co-insurance is made at the time of scheduling your appointment. The deposit may be paid with cash, personal check, Visa, MasterCard, Discover, American Express, or financing through HealthCare Finance. Your remaining *estimated* co-insurance will be due by you on the day of treatment. We will process your insurance information, collect the funds directly from the insurance company, and apply to your account. Should there be a credit on your account, we will promptly refund that amount to you. Should your insurance provider not cover the full amount and there is a balance due, we will send you a statement that is due without delay. If we have not received payment from the insurance company within 90 days of your treatment, you will be billed the balance and your payment is due without delay. Interest will be charged at 1.5% per month for all accounts over 90 days old. If, after 90 days you have settled your account with us and we finally receive payment from your insurance company, we will promptly remit to you the insurance payment. Should your account be referred to an outside collection agency due to lack of payment, you are responsible for all fees associated with collecting the money owed.

Typically we receive insurance payments within 90 days of submitting a claim. However, it is your responsibility to ensure that your account has been settled by this time. We encourage you to keep informed of the status of your insurance claim with your insurance provider. It is our experience that the more up to date you are with the status of your insurance, the faster the claims will be processed.

If you do not have dental insurance, payment is due, in full, at the time of treatment. Again, for you convenience, we accept cash, personal check, Visa, MasterCard, Discover, American Express or financing through HealthCare Finance or Care Credit. Your account will be charged a $25 returned check fee for any returned checks due to non-sufficient funds.

Please select your method of payment:

☐ **Please bill by dental insurance and I will pay my co-insurance with either Cash, Personal Check, Visa/MasterCard, AMEX, Discover, HealthCare Finance, or Care Credit.**

☐ **I do not have insurance and I will pay for treatment in full with either Cash, Personal Check, Visa/MasterCard, AMEX, Discover, HealthCare Finance, or Care Credit.**

I have read and fully understand the payment policy of this office. I have had all my questions answered to my satisfaction regarding the payment options available to me. I agree to the above information and terms.

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT PRINT NAME DATE

CANCELLATION POLICY

There is a **$50.00 cancellation fee** for all appointments that are "no showed" (no call or pre-notification within 24 hours of your absence given to this office). This is necessary due to the high demand for appointments in our office. It is also a courtesy to notify us as soon as possible if you are not able to attend your appointment so that we may offer your appointment to other patients who may be in need of emergency care or have been waiting for an appointment to come available. The cancellation fee will need to be paid if full before your appointment will be rescheduled. We understand that emergencies do happen and will do our best to work with you in those situations. If an appointment is "no showed" twice, we will not be able to reschedule the appointment. Please understand that this is in the interest of serving all of our patients in a timely manner.

I have read and fully understand the cancellation policy of this office. I have had all my questions answered to my satisfaction regarding the cancellation policy. I agree to the above information and terms.

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT PRINT NAME DATE

East Valley Implant & Periodontal Center

Dr. Todd F. Jorgenson, DMD, MS
3048 E. Baseline Rd., Suite 112
Mesa, AZ 85204

Patient Consent/Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Todd F. Jorgenson, DMD, MS, our staff, and our business associates (your general dentist, other specialists, and your insurance) for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice. We will also post any revised Notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree on these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use and disclosure of your protected health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgement of receipt of **OUR NOTICE** of privacy practices or to document our good faith effort to obtain that acknowledgment.

I have reviewed, understand and agree to the consent of the notice of privacy.

Print Name_____ Date_____

Signature_____

If refuse, please specify the exact reason why the patient chose not to sign the consent/acknowledgment of notice of privacy.