# NEW PATIENT FORM

**Date:** **Office:** **Patient:**

## Patient Information ( Minor: Yes / No )

**Full Name:** _____ **Prefer to be called:** _____

**Birthdate:** _____ **Age:** _____ **SS#:** _____ **Sex:** M F

**Address:** _____

**Phone** Home: _____ Work: _____ Cell: _____

**Email:** _____ **Employer:** _____ **Marital status:**_____

**Spouse's Name:** _____ **# of children under 14:** _____ **# of children above 14:** _____

**Emergency Contact:** _____ **Emergency Phone:** _____

**How did you hear about us:** ▢ Social Media ▢ Google ▢ Insurance ▢ Family / Friend ▢ Other

## Responsible Party

**Name of person responsible for account:** _____ **Relationship to patient:**_____

**Address:** _____

**Phone** Home: _____ Work: _____ Cell: _____

**Employer:** _____ **SS#:**_____ **Date of birth:** _____

**Preferred payment method:** _____

## Insurance Information

**Insurance Company:** _____ **Group #:** _____ **ID#:** _____

**Insurance Phone #:** _____ **Insurance Address:**_____

**Policy Holder's name:** _____ **Employer:**_____ **Work Phone:** _____

**DOB Policy Holder:** _____ **SS#:**_____ **Relation to Patient:** _____

**Secondary Dental Insurance:** YES NO

## Dental History

**Previous Dentist:** _____ **Previous Clinic:** _____

**Times a day you brush:** _____ **Times a week you floss:** _____ **Rating of your smile (1-10):** _____

**Require antibiotic pre-med:** _____

## Medical History

**Physician:** _____ **Office Phone:** _____ **Date of last visit:** _____

**Under medical treatment?:** Yes No **If yes, explain:** _____

_____

**Hospitalized within last 5 year?:** Yes No **If yes, explain:** _____

_____

**Taking blood thinner?:** Yes No **If yes, explain:** _____

_____

**Taken Phen Fen?** Yes No **Use tobacco?** Yes No **If yes, how long?** _____

**Taken Bisphosbhonates?:** Yes No **If yes, how long?:** _____ **Controlled substances?** Yes No

## Are you allergic to or had reactions to any of the following?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Local Anesthetics | | | Penicillin | | |
| Any metals | | | Latex Rubber | | |
| Codeine | | | Other _____ | | |

## Do you now have or have you ever had any of the following?

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | | | Diabetes | | | Heart Murmur | | | Mitral Valve Prolapse | | |
| Seizures | | | Anemia | | | Thyroid Problems | | | Tuberculosis | | |
| Liver Disease | | | Cardiac Pacemaker | | | Rheumatic Fever | | | Kidney Disease | | |
| Emphysema | | | STD | | | Glaucoma | | | Radiation Therapy | | |
| Low Blood Pressure | | | Heart Attack | | | Swollen Ankles | | | Epilepsy / Convulsions | | |
| Asthma | | | AIDS/HIV | | | Stroke | | | Fainting | | |
| Heart Disease | | | Respiratory Problems | | | Leukemia | | | Cancer | | |
| Joint Replacement | | | Stomach Problems | | | Hay Fever/ Allergies | | | Hepatitis/Jaundice | | |

## Personal Medication List

| Prescription Medication | Purpose or Reason Taken | Dose | Time(s) of Day | Form (liquid, capsule, tablet) | Special instructions |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## Sleeping and Breathing Health

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Do you usually wake feeling tired or unrested? | | | Do you habitually snore? | | |
| Do you suffer from waking headaches? | | | Do you experience daytime drowsiness? | | |
| Has anyone observed you not breathing while sleeping? | | | Do you have blocked nasal passages? | | |
| Do you grind your teeth while sleeping? | | | Do you ever wake up choking/gasping? | | |

## Women Only

| | YES | NO |
|---|---|---|
| Are you Pregnant or think you might be pregnant? | | |
| Are you Nursing? | | |
| Are you taking contraceptives? | | |

## Authorization & Release

| | YES | NO |
|---|---|---|
| Do you accept to share this information with Professional Dental? | | |

Signature _____ Full Name _____ Relation to patient _____ Date _____

Doctor Signature _____ Doctor Full Name _____

# CONSENT FORM

| Date: | Office: | Patient: |
|---|---|---|

I authorize Professional Dental and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an outward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment, items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs for the prevention of osteoporosis, such as Fosamax, Boniva, Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I also acknowledge that all of the preceding answers and information provided on all forms filled out are true and correct. If I ever have any change in my health or there are changes in my child's health, I will inform Professional Dental at the next appointment without fail. If changes are not reported, I agree that any damage incurred will be my sole responsibility, financially and legally. I acknowledge that I have the right to refuse treatment at which time I must sign the proper refusal forms. I agree that I will be responsible for any damage incurred if prescribed treatment is not rendered within the reasonable prescribed amount of time.

I accept Professional Dental Consent Form:

| Signature | Full Name | Relation to patient | Date |
|---|---|---|---|

# OFFICE FINANCIAL POLICY

| Date: | Office: | Patient: |
|---|---|---|

We are happy you have chosen Professional Dental as your dental provider. We accept many different insurances to benefit our patients. As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon the reimbursement from our patients for the costs incurred in their care, to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that it is their responsibility to provide correct/updated insurance information. All dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all services. Professional Dental is happy to submit insurance forms and help resolve outstanding claims to the insurance company designated by you. You must understand that not all insurance companies pay in full for estimated services rendered. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec.12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Professional Dental or anyone acting on its behalf. I understand and agree that such calls may be initiated by Professional Dental or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

I agree that if payment cannot be made at the time of service, treatment may be denied and I am responsible for any costs incurred. I agree that any verbal agreement for payment is a legal agreement and I will be held to such agreements until the balance of my account is paid off.

I understand that there will be $25 charge on all returned checks. I understand that after one check is returned, the only method of payment this office can accept is cash or credit. I understand that 24-48 hours notice is required to cancel an appointment. In order to keep costs low, I agree that I must be at each appointment as agreed and scheduled. A minimum of a $60 charge will be made for broken or failed appointments.

I accept Professional Dental’s Office Financial Policy:

| Signature | Full Name | Relation to patient | Date |
|---|---|---|---|

# HIPAA Compliance Patient Consent Form

## Acknowledgement of receipt of notice of privacy practices

| Date: | Office: | Patient: |
|---|---|---|

I acknowledge that I have received a copy or had the opportunity to read Professional Dental's Privacy Policy (HIPAA agreement). I hereby agree to abide by the condition outlined herein. (You may refuse to sign this acknowledgment).

| | YES | NO |
|---|---|---|
| **I acknowledge receipt of Professional's Dental Notice of Privacy Practices.** | | |

| Signature | Full Name | Relation to patient | Date |
|---|---|---|---|

## For Office Use Only:

☐ Individual Refused to Sign

Other: