SPRINGVILLE DENTISTRY

378 East 400 South, Suite 1
Springville, UT 84663
801-489-9456

SPANISH FORK DENTISTRY

1284 Canyon Creek Parkway
Spanish Fork, UT 84660

Personal Information

Date _____

Name _____ Gender: ☐ Male ☐ Female
First Mil Last Preferred

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow Spouse name _____

Birth Date _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____ Other _____

E-mail Address _____ Drivers License Number _____ State ____

Employer _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____ Relation to Patient _____

Whom may we thank for referring you to us? _____

Responsible Party

(If different from above)

Name _____ Relation to Patient: ☐ Parent ☐ Self Other _____

Birth Date _____ Social Security Number _____ Gender Male ☐ Female ☐

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____ Other _____

E-mail address _____ Drivers License Number _____

Employer _____

Address _____ City _____ State _____ Zip _____

Insurance Information

Primary

Name of Insured _____

Birth Date _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent

Insurance Plan _____

Employer _____

ID # _____

Group # _____

Insurance plan address _____

City _____ State _____ Zip _____

Secondary

Name of Insured _____

Birth Date _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent

Insurance Plan _____

Employer _____

ID # _____

Group # _____

Insurance plan address _____

City _____ State _____ Zip _____

Personal Health History

Primary Care Physician Name_____ Phone _____

1. Do you consider yourself in good health? Yes No
2. How long has it been since you have seen a dentist? _____ Dentist's name _____
3. Have you ever had any severe reaction to dental treatment or local anesthetics? Yes No
4. Have you ever taken Phen-Fen or similar appetite suppressants? Yes No
   If yes, have you seen your physician or cardiologist for a cardiac evaluation? Yes No
5. Have you ever taken AREDIA, BONEFOS, DIDRONEL or ZOMETA for treatment of Breast /Prostate Cancer or Multiple Myeloma Yes No
6. Have you ever or are currently taking FOSAMAX, ACTONEL, or BONIVA for Osteoporosis or Paget's disease Yes No
5. Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Hay Fever	☐	☐	Radiation Treatment	☐	☐
Alcohol counseling	☐	☐	Head Injuries	☐	☐	Pacemakers	☐	☐
Arthritis	☐	☐	Headaches	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	☐	☐
Blood Disease	☐	☐	Heart Murmur	☐	☐	Rheumatism	☐	☐
Blood Problems	☐	☐	Heart Problems	☐	☐	Sensitive Gums	☐	☐
Bleed/Bruise Easily	☐	☐	Hepatitis Type_____	☐	☐	Seizures	☐	☐
Bleeding Gums	☐	☐	High Blood Pressure	☐	☐	Sinus Problems	☐	☐
Cancer	☐	☐	HIV/AIDS	☐	☐	Stomach Problems	☐	☐
Circulation Problems	☐	☐	Immune System Disorders	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Jaundice	☐	☐	Thyroid Problems	☐	☐
Emphysema	☐	☐	Kidney Disese	☐	☐	TMD	☐	☐
Epilepsy	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Excessive Bleeding	☐	☐	Low blood Pressure	☐	☐	Tumors	☐	☐
Fainting/Dizziness	☐	☐	Mental Disorders	☐	☐	Ulcers	☐	☐
Glaucoma	☐	☐	Nervous Disorders	☐	☐	Venereal Disease	☐	☐
Growths	☐	☐	Prescription Drug Counseling	☐	☐	Other _____		

6. Have you ever had a joint replacement? Yes No If yes, what joint(s) and when _____
7. Do you require antibiotic pre-medication for heart conditions, artificial valves, or artificial joints? Yes No
8. Do you use tobacco products? Yes No
9. Do you like nitrous oxide (laughing gas)? Yes No Unsure
10. WOMEN: Are you Pregnant? Yes No Due date? _____
11. Do you have any other concerns? Yes No Specify _____

Medications

List any medications including birth control and herbal supplements:

_____
_____
_____
_____

Allergies

- ☐ Acetaminophen
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Latex
- ☐ Local anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other _____

Health Questionnaire Acknowledgement and Consent To Proceed

I herby certify that the answers to the foregoing health questions are accurate and correct to the best of my knowledge. Since a change of medical conditions and/or medications can affect dental treatment, I understand the importance of and agree to take the responsibly to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Richard Francis, Dr. Kyle Marshall, Dr. Eric Swenson, Dr. Rachel Shaw, Dr. Aaron Galbraith and Dr. Matthew Ream and/or such associates or assistants as she/he may designate to perform those procedure 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 untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleaning's and basic dentistry, including filling of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. 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 crown, 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 procedure 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 prescribed for the prevention of osteoporosis may result in complications of non-healing of the jawbones following oral surgery.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hope 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.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)

Witness _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

'You May Refuse to Sign this Acknowledgement'

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name of Patient

_____
Signature of Patient or Legal Guardian

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

OFFICE FINANCIAL POLICIES and FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon 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. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to be rendered to me, or at my request, to my minor child or ward, by the dentist, I agree to pay the fees charged for the dental services provided to me or my assignee at the time that the services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. I authorize the dentist or designees to assign a fee of twenty five dollars ($25) per every half hour in length of a failed appointment if notification is not given to the dentist at least twenty four (24) hours in advance.

1 herby 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 Springville Dentistry or anyone acting on its behalf. I understand and agree that such calls may be initiated by Springville Dentistry 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 service and/or the use of text messages - some or all of which may result in data charges. I also consent to receive e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____	_____	_____
Signature of patient, parent or guardian	Date	Relationship to patient