Welcome!
Holladay Hills Dental

Date _____

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ *Nickname* _____ *Sex* ☐ *M* ☐ *F*
Last First MI
Birthdate _____ *Age* _____ *SS#* _____
Address _____ *City* _____ *St* _____ *Zip* _____
Home Phone _____ *Work Phone* _____ *Cell* _____
Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*
If Patient is a minor, give Parent/Guardian's name _____
Person to contact in case of emergency _____ *phone #* _____
Relationship to patient _____

*****Whom may we thank for referring you to our office?** (please circle one)
Insurance Internet/Website Phone Book Other Friend/Family: _____
Name of Individual

RESPONSIBLE PARTY

Name _____ *Sex* ☐ *M* ☐ *F* *Driver's Licence #* _____
Last First MI
Birthdate _____ *Age* _____ *SS#* _____
Address _____ *City* _____ *St* _____ *Zip* _____
Home Phone _____ *Work Phone* _____ *Cell* _____
Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*
Relationship to Patient _____

Co-Payment Must Be Paid In Full At Each Appointment.
For your convenience, we offer the following methods of payment. Please circle the option you prefer.
☐ *Cash* ☐ *Personal Check* ☐ *Credit Card* ☐ *CareCredit (OAC)*

PRIMARY INSURANCE INFORMATION

Name of Insured (policy holder) _____ *SS# /ID#* _____
Birthdate _____ *Daytime Phone* _____
Name of Employer _____
Insurance Company _____ *Group #* _____
Insurance Co. Address _____ *City* _____ *St* _____ *Zip* _____

SECONDARY INSURANCE INFORMATION

Name of Insured (policy holder) _____ *SS# /ID#* _____
Birthdate _____ *Daytime Phone* _____
Name of Employer _____
Insurance Company _____ *Group #* _____
Insurance Co. Address _____ *City* _____ *St* _____ *Zip* _____

PATIENT MEDICAL HISTORY

PATIENT NAME _____ **Birth Date** _____

Although dental personnel primarily treat the area 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	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisophonates?	☐ Yes ☐ No	_____
Are you on a special diet?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	
Do you have, or have you had an Eating Disorder?	☐ Yes ☐ No	

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? (please circle)

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other: If yes, please explain: _____

Do you have, or have you had, any of the following? (please circle)

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No _____

Comments:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the 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. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) *Date*

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 and 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 by cash, credit card or check at the time services are rendered.

Holladay Hills Dental charges a $35 Missed Appointment fee for appointments broken or cancelled without 24 hours notice. As a responsible patient, I agree to pay the $35 Missed Appointment Fee for any failed or cancelled appointments without 24 hours advance notice. I understand, that I am responsible for my appointment and that confirmation calls from Holladay Hills Dental are done as a courtesy only.

Patients who carry dental insurance understand that all charges for dental services rendered are the responsibility of the patient. As a convenience to you, Holladay Hills Dental will verify Patient insurance benefits and have the patient pay any *estimated* co-pay on the date services are rendered. Our office will prepare the insurance forms of our patients and assist in making collections from insurance companies. **However, Patients who carry dental insurance understand that all charges, regardless of insurance coverage, are ultimately the patients responsibility. PLEASE KEEP IN MIND, ALL CO-PAYS COLLECTED ON DATE OF SERVICE ARE ONLY ESTIMATES.**

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previous written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. **I agree to pay all attorney costs and/or collection fees, up to 47%, to collect monies owed by me.** I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, services rendered, dates of service, 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 and/or my account.

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 paper form to my insurance carrier or any related entities that require such information to be submitted. I hereby agree to abide by the conditions outlined herein.

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

General Informational Informed Consent

Welcome to our office, we are grateful for the opportunity to serve you. We sincerely desire to provide you with the highest quality dental care available. We want you to understand that, though rare, there are certain inherent risks in the practice of dentistry that must be accepted by the patient in order to receive treatment. We do everything in our power to minimize these risks. Not having dental treatment also caries risks including, but not limited to, non-restorable tooth decay, premature loss of teeth, pain, infection, swelling, periodontal (gum) disease, malocclusion (improper bite), and bone loss. The following is a list of some of the possible risks associated with dental treatment in general, but is not all-inclusive. We will also ask for your consent for individual procedures before treatment is started, during which time the specifics concerning particular procedures will be explained. We are always happy to answer any questions you may have at any time.

1. **Longevity of dental treatment**: Though dental restorations (i.e. fillings and crowns) may last for several years or longer, nothing will last forever. Longevity depends upon many factors, including, but not limited to, home care, hygiene, diet, habits, materials used, genetics, and medical health.
2. **Medical health**: Your medical health and/or treatment may affect your dental health and/or treatment, and, likewise, your dental health and/or treatment may affect your medical health and/or treatment. It is very important that you always notify the dentist of any new information or changes concerning your medical health or treatment as quickly as possible.
3. **Reactions to drugs, medications or dental materials**: We only use products of the highest quality, but untoward reactions to drugs, medications or dental materials sometimes occur, and are generally unforeseeable.
4. **Injury to adjacent teeth or oral tissues**: In the process of treating dental or periodontal disease in one area of the mouth, the potential to injure adjacent teeth or other tissues exists.
5. **Teeth sensitivity or pain**: After the placement of any restoration (i.e. filling or crown), teeth involved may occasionally become sensitive, especially to temperature change or biting pressure. This usually resolves over a period of weeks to months, but in rare cases may take longer. Sensitivity or pain may also be a sign of other problems that may require different or additional treatments. Please call us immediately with any concerns or questions; it is your responsibility to inform us of any problems if they occur so we may help you.
6. **Post-operative pain or discomfort**: Occasionally following dental treatment, generalized pain, soreness, and/or discomfort in the jaw, mouth, lips, gums or teeth may occur. This is usually only temporary and resolves quickly with normal healing processes, but may be a sign of other problems requiring additional treatment. Also, post-operative recovery may necessitate home recuperation and time away from work, school, or play. Please call us immediately with any concerns or questions; it is your responsibility to inform us of any problems if they occur so we may help you.
7. **Additional treatment**: Every effort will be made to restore teeth and treat periodontal (gum) disease definitively according to an initial treatment plan. However, due to unforeseen circumstances, additional treatments are sometimes necessary to properly and definitively treat dental problems. Also, during procedures it is sometimes necessary to modify the planned treatment as new information or problems are discovered. You will always be informed of such changes. These changes may lengthen the time required to properly treat you, may increase the number of visits required, and may increase the originally planned cost of treatment.
8. **Cracks and/or fractures**: Tooth decay and subsequent tooth restorations (i.e. fillings and crowns) weaken tooth structure. Following dental treatment, restored teeth may occasionally break, crack, or fracture requiring additional treatments or sometimes rendering teeth non-restorable.
9. **Injury of nerves**: There is a possibility of injury to the nerves of the face, lips, jaws, tongue, teeth, gums, or other oral or facial tissues in the normal processes of dental treatment, particularly those involving the administration of local anesthetics. The resulting anesthesia or paresthesia (numbness) which may occur is usually temporary (i.e. several weeks to several months), but in rare instances may be permanent.
10. **Aesthetics or appearance**: Every effort will be made to closely approximate the natural or desired tooth color and appearance. However, it is not always possible to achieve the results desired by all patients, and there are no guarantees made in this regard. Also, due to hygiene, diet, smoking, etc., restorations (i.e. fillings and crowns) may discolor or wear over time requiring replacement and/or other additional treatments.
11. **Referral to other dentists or specialists**: We strive for excellence in all of our work, and always place your best interests first. We only perform services in our office that we can accomplish with the highest degree of quality. Occasionally it is necessary to refer you to a specialist to perform or complete a procedure. This may sometimes increase the cost of treatment and/or the length of time required for treatment. Also, it is sometimes necessary for various reasons to refer you to another general dentist for all or a portion of your treatment.
12. **Financial arrangements**: We want to make financial arrangements that are comfortable for you. Please make sure you read and understand our office's financial policies. We would be happy to answer any questions you might have, and help you make any necessary arrangements before beginning treatment. Thank you.

_____	_____	_____
Patient's (or Legal Guardian's) Signature	Date	Relationship to Patient

Witnessed by (Asked for and/or Answered Questions): _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____