Welcome to

Patient Name ____________________________ Preferred Name ?__________________________ Date: _________

Birth Date ___/___/___ Age:___ SSN#:_______________ Sex: M F

Mailing Address: _______________________________________ City: ________________ State: _____ Zip:_______

Home Phone: _______________ Work Phone:______________ Cell Phone: _______________

Email Address: ____ Employer:___________________________

Spouse's Name:_____________________ Do you have children? No Yes How many? _____

Status:(Please circle one) Minor SingleMarried Divorced Widowed

Emergency Contact: Name ________________Phone #:_________________Relation:_________

How did you hear about us? (circle all that apply) Mailer Website Insurance Sign/walk in

Family/Friend Name: ______________________________ Other __________________________

Responsible Party Check if same as above _______
Name of person responsible for account________________________ Relationship to patient________
Mailing Address: ______________________________ City: __________________ State: _______ Zip: _____
Home phone: _______________ Cell Phone:_______________ Work Phone: _____________ DOB:____
Employer: _______________________________ SSN: __________________________

For your convenience, we offer the following methods of payment:

Please circle the option you prefer: Cash Check Credit Card Carecredit/Financing options

Insurance Information Insurance Company Name: ___________________ Group#:___________ ID#:________________
Insurance phone #:________________ Insurance Address: ____
Employer:________________ Work Phone #:________________ Name of policy holder:_______________________________
DOB of policy holder: ________ SSN# of policy holder:_____________________Relationship to patient__________________

Dental History Previous Dentist and location: ____
Times a day you brush__________ Times a week you floss___________ How would you rate your smile(1-10)______
Do you require antibiotic premedication before any dental treatment? No, If yes, please explain_______________
Do you have any of the following? **Circle all that apply** Snoring Dental Anxiety
Red, swollen and/or bleeding gums Broken or chipped teeth Clicking or pain in joint
Pain in teeth Sores or lumps in or near mouth Clenching or grinding of teeth
Teeth sensitive to hot, cold and/or sweets Lost or broken fillings Bad breath

Medical History **Patient Name:** ______________________________

Physician: ____________________ Office Phone #:______________ Date of last visit:________
Are you under medical treatment now? No If yes, please explain:______________________

Have you been hospitalized for any surgical operations or serious illness within the last 5 years? No If yes, please explain: ____

Are you taking any medications and/or blood thinners? No If yes, please list: **(please bring a list we can copy for our records)**____
Have you ever taken Phen Fen? Yes No Do you use controlled substances? Yes No
Do you use tobacco? No If yes, used how and how long?:____
Have you ever taken Bisphosphonates (Boniva or Fosamax?)
Yes No If yes, how long ago?____

Allergies Are you allergic to or had a bad reaction to any of the following? **Circle all that apply**

Local Anesthetics (eg Novocain)	Codeine
Penicillin or any other antibiotics	Other (please explain)______________________________________
Latex Rubber	____
Any metals (eg Nickel, Mercury, etc)	____

Do you now have or have you ever had any of the following? **Circle all that apply**

High Blood Pressure	Seizures	Liver Disease	Emphysema
Low Blood Pressure	Asthma	Heart Disease	Joint replacement
Diabetes	Anemia	Cardiac Pacemaker	STD_____________
Heart Attack	Aids/HIV	Respiratory issues	Stomach Ulcers
Heart Murmur	Thyroid Problem	Rheumatic Fever	Glaucoma
Swollen Ankles	Stroke	Leukemia	Hay Fever/Allergies
Mitral Valve Prolapse	Tuberculosis	Kidney Disease	Radiation Therapy
Fainting	Epilepsy/Convulsion	Cancer	Hepatitis/Jaundice

Other (please explain):____

Women Only Are you pregnant or think you might be? Yes No
Are you Nursing? Yes No Are you taking contraceptives? Yes No

Authorization & Release
Signature of Patient (or Parent if Minor) X______________________________ Date: _______________
Acknowledgement of receipt of notice of privacy practices: I acknowledge that I have had the opportunity to read Summit View Dental's Privacy Policy (Hippa agreement) and understand they will protect my health information from being disclosed without my consent.

Reviewed by Office (Office Use Only)
Name:______________________Signature X______________________________ Date: _______________

Consent to Proceed

I authorize Summit View Dental and/or such associates or office staff 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 of 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 preventative 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/sore after treatment. Although rare, it is 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 risk of substantial and serious harm, if any which may be associated with general preventative 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 Summit View 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.

X______________________________ X____________________________________ Date__________________

Name of Patient Signature of Patient or legal guardian

Office Financial and Truth in Lending Statement

We are happy you have chosen Summit View 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 in a timely manner. All dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all services even if insurance does not cover it. Summit View 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 amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts 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 Summit View Dental or anyone acting on its behalf. I understand agree that such alls may be initiated by Summit View Dental or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies/or third-party collection agencies and that the methods of contact may include using pre-recorded/artificial voice messages and/ore 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 email at any email provided by me or anyone associated with me or acting on my behalf.

I agree that if payments 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 a $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 $60.00 an hour charge will be made for broken or failed appointments.**

X______________________________ X____________________________________ Date__________________

Name of Patient Signature of Patient or legal guardian