Dental Registration

Patient Information:

Date: __________ Patient Name: ______________________________Preferred:___________
Birth Date: __________________ Age: _________ SSN: __________________________
Mailing Address: ____ Apt #: ________
City: ________________________ State: ______________ Zip Code: ________________
Email Address: ____
(This will be used for appointment reminders, payment receipts, etc.)

Whom may we thank for referring you? ____

Please circle applicable:

Male	Married	Divorced	Child
Female	Single	Widowed	Partnered

Please fill in all applicable and circle preferred method of contact:
Home Phone: ____________________ Cell Phone: ____________________
Work Phone: ____________________ Best time to reach you: __________________

Preferred method(s) of contact: Email Text Calls

Occupation: ____________________________ Employer: ____________________________
Employer Address: ____
Spouses Name: ______________________ Birth Date: ______________ SSN: _________________
Spouses: Occupation: __________________________ Employer: ____________________________
Emergency Contact Name:_____________________ Phone Number:________________________
Relationship To Patient:_______________________

Dental Insurance:

Name of Insurance Company: ____
Name of Policy Holder: ______________________ Birth Date: _____________
SSN: ____________ Subscriber ID#: _____________________________
Group #: ____________________________

Secondary Coverage Yes: ___ No ___

Name of Secondary Insurance Company: ____
Name of Policy Holder: ______________________ Birth Date: ________SSN:____________
Subscriber ID#: _____________________________ Group #: ________________________

Medical and Dental History

Reason for today's visit: ____
Former Dentist: _______________ Approx. date of last dental visit:______________
Please mark to indicate if you have had any of the following:

☐ Bad breath	☐ Foreign objects	☐ Periodontal treatment
☐ Bleeding gums	☐ Grinding teeth	☐ Sensitivity to cold
☐ Blisters on lips or mouth	☐ Gums swollen or tender	☐ Sensitivity to heat
☐ Burning sensation on tongue	☐ Jaw pain or tiredness	☐ Sensitivity to sweets
☐ Chew on one side of the mouth	☐ Lip or cheek biting	☐ Sensitivity when biting
☐ Cigarette, pipe or cigar smoking	☐ Loose teeth or broken fillings	☐ Sores or growths in your mouth
☐ Clicking or popping jaw	☐ Mouth breathing	☐ Do you snore
☐ Dry mouth	☐ Do you have a CPAP	☐ Have you been told you snore
☐ Fingernail biting	☐ Have you ever done a sleep study	☐ Orthodontic treatment
☐ Food collection between teeth	☐ Mouth pain, brushing	☐ Pain around ear

☐ How often do you brush? _________ ☐ How often do you floss? _________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fastin (Brand names of phentermine), Pondimin (Fenfluramine) and Redux (dexfenfluramine). Yes__ No__

☐ AIDS/ HIV	☐ Emphysema	☐ Radiation treatment
☐ Anemia	☐ Epilepsy	☐ Respiratory disease
☐ Arthritis	☐ Fainting or dizziness	☐ Rheumatic fever
☐ Artificial Heart Valves	☐ Glaucoma	☐ Scarlet fever
☐ Artificial joints	☐ Headaches	☐ Shortness of breath
☐ Asthma	☐ Heart murmur	☐ Sinus trouble
☐ B-12 Deficiency	☐ Heart problems	☐ Skin rash
☐ Back problems	☐ Hepatitis Type___	☐ Special diet
☐ Bleeding abnormally, with extractions or surgery	☐ Herpes	☐ Stroke
	☐ High blood pressure	☐ Swollen feet or ankles
☐ Blood disease	☐ Jaundice	☐ Swollen neck glands
☐ Cancer	☐ Jaw pain	☐ Thyroid problems
☐ Chemical dependency	☐ Kidney disease	☐ Tonsillitis
☐ Chemotherapy	☐ Liver disease	☐ Tuberculosis
☐ Circulatory problems	☐ Low blood pressure	☐ Tumor or growth on head
☐ Congenital Heart lesions	☐ Mitral valve prolapsed	☐ Other_____________

☐ Cortisone treatments
☐ Cough, persistent or bloody
☐ Diabetes
☐ Nervous problems
☐ Pacemaker
☐ Psychiatric care
☐ Ulcer
☐ Venereal disease
☐ Weight loss, unexplained

Women:
Are you pregnant: ______ Due Date: ____ Trimester 1st 2nd 3rd
Taking birth control pills Y___ N___ Nursing Y___ N___

Medications: List any medications you are taking and correlating diagnosis:
____
____
____
____

Allergies:

☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other

Four Seasons Dental
4465 S. 900 E., Suite 100
Salt Lake City, UT. 84124

FINANCIAL POLICY and FEDERAL TRUTH IN LENDING STATEMENT

Thank you for choosing us for your dental needs we are committed to providing you excellent care and payment for services rendered is a part of successful treatment. Our financial policy is based on an open and honest discussion of our fees. Please, read, sign and return the following.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. We offer the following options for payment.
1. We accept cash, VISA, MasterCard, Discover and American Express
2. We offer payment plans through Care Credit only. If you are interested in applying , please see our office staff for details. Any and all financial arrangements must be made prior to treatment.

Insurance:
As a service to our patients, we will bill your insurance company, however, your co-payment amount or percentage of the bill is expected at the time of service. All co-payments are based upon estimates only and in the event that your insurance company pays less than estimated, you are responsible for the difference. You are also responsible for any unpaid claims from your insurance company after 90days. In the event that your insurance company pays ,we will refund the amount to you. We cannot render services on the assumption that the charges will be paid in full your insurance company.

Minors:
Payment for services rendered to a minor child can be made by credit/debit card or cash. Payment is the responsibility of the adult accompanying the minor at the time of service.

Dental Visits:
All dental services, or any emergency services rendered, must be paid in full at the time of service. (For those with insurance only estimated copayments due) A fee of $20 will be applied to your account if payment is not received at the date of service. Further fees for late payments may apply.

Missed Appointments:
There will be a $35 charge per hour for missed appointments or appointments cancelled with less than a 24 hour notice.

Service Charges:
It is our policy to charge interest of 1.75% per month (21% APR) which will be applied to all accounts over 60days past due, unless prior financial arrangements have been made. There will be a $40 dollar charge for any returned checks.

Collection Fees:
Should your account be turned over to collections, the undersigned agree to pay the costs to collect the debt, including but not limited to: Interest in the amount of 18% annum, attorney's fees, court costs and collection fees in the amount of 40% the obligation to pay the collection fees shall be imposed at the time of the assignment of the debt to a third party collection agency.

Financial Consent:
The patient (or guardian) agrees to be fully responsible for total payment of treatment rendered in this office.
I understand and agree to this Financial Policy. I authorize to release financially identifiable information and the treatment descriptions and information to my insurance carrier or any related entities that require such information.

____ ____________________
Signature of responsible party Date

_Print Name:____

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Consent to Proceed

I authorize Dr. Eric Smith and/or such associates or assistants to perform those procedures as may be deemed necessary or advisable to maintain my dental health or that of any minor or other individual for which I have responsibility. These may include arrangement or administration of any sedative (including nitrous oxide) analgesic, therapeutic and/or other pharmaceutical agents.
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, 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 my 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/or 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 my dental treatment, items including, but not limited to crowns, small dental instruments, drill components, etc., may be aspirated (inhaled) or swallowed. This unusual situation may require bronchoscopy or other procedures to ensure safe removal.
I understand the need to disclose to Dr. Smith and /or such associates 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 for non-healing of the jawbone 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 preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved for my benefit (or minors) benefit. I acknowledge that the nature and purpose of the forgoing procedures have been explained to me if necessary, and I have been given the opportunity to ask questions.

____ ____________________
Signature of responsible party Date

____ ____________________
Print Name Witness to Signature

<u>HIPPA</u>

I acknowledge that I have reviewed a copy of this offices privacy policy on ________________________.
Date

____ ____
Signature Print Name

I authorize the discussion of my treatment or appointments with immediate family members

____
Signature