ART CITY DENTAL PATIENT INFORMATION

Date:_____

Patient's Name:_____Birthdate:_____ Age_____

Address:_____ City:_____ Zip Code:_____

Sex: M ◯ F ◯ Patient's Social Security #:_____ Marital Satus: M ◯ S ◯ W ◯ D

Home Phone #:_____ Cell Phone #: _____ Text Messages? Y ◯ N ◯

Employer: _____ Business Phone #:_____

Employer address:_____ Work in office ◯ From home ◯

Is Patient a full time student? Y ◯ N ◯ Name of School: _____

Email:_____ Referred by:_____

Spouse's Name: _____ Spouse's Birthdate: _____

Spouse's Social Security #:_____ Spouse's Employer:_____

Person to contact in case of emergency: _____ Relationship: _____

Address: _____ Phone #:_____

Name of responsible party:_____ Relationship:_____

Address:_____ City:_____ Zip Code:_____

Home Phone #:_____ Cell Phone #:_____

Birthdate:_____Social Security #:_____

Employer:_____Employer's Phone#:_____

Employer's address:_____ City:_____ Zip Code:_____

Will Dental Insurance be involoved? Yes ◯ No ◯ If yes, please complete the next section

PATIENT INSURANCE INFORMATION (use your identification card)

Subscriber's Name:_____ Subscriber's SSN:_____

Subscriber's Birthdate:_____Your relationship to subscriber: Self ◯ Spouse ◯ Child ◯ Other ◯

Name of Insurance Company:_____ Subscriber ID #:_____

Group #:_____ Effective Date:_____ Insurance Company Phone #:_____

Address where claim should be sent:_____

Subscriber's Employer:_____Employer's Phone#:_____

SECONDARY INSURANCE INFORMATION

Subscriber's Name:_____ Subscriber's SSN:_____

Subscriber's Birthdate:_____Your relationship to subscriber: Self ◯ Spouse ◯ Child ◯ Other ◯

Name of Insurance Company:_____ Subscriber ID #:_____

Group #:_____ Effective Date:_____ Insurance Company Phone #:_____

Address where claim should be sent:_____

Subscriber's Employer:_____Employer's Phone#:_____

ART CITY DENTAL
801.489.4411 ARTCITYDENTAL.COM

Medical History for Patient: _____ Date: _____

Although our Dental Team primarily treats areas in and around your mouth, the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible. Thank you!

Are you required to Pre-medicate?	☐ Yes	☐ No	If yes, please explain: _____
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: _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes, please explain: _____
Do you Consume Alcohol?	☐ Yes	☐ No	If yes, please explain: _____
Do you use tobacco?	☐ Yes	☐ No	If yes, please explain: _____
Do you use controlled substances?	☐ Yes	☐ No	If yes, please explain: _____

Please list any medications, pills, or drugs you are taking: _____

_____

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Meta ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Other _____

_____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Shingles
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A, B, C	☐ Sickle Cell Disease
☐ Anaphylaxis	☐ Drug Addiction	☐ Headaches	☐ Sinus Trouble
☐ HPV/STI/STD	☐ Easily Winded	☐ Scarlet Fever	☐ Spina Bifida
☐ Angina (Chest pain)	☐ Auto Immune Disease	☐ High Blood Pressure	☐ Tonsillitis
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Tuberculosis
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Ulcers
☐ Artificial Joint	☐ Infective Endocarditis	☐ Irregular Heartbeat	☐ Other Serious Illness: _____
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ If marked yes to anything listed, please explain…
☐ Blood Disease	☐ Frequent Cough	☐ Rheumatic Fever	_____
☐ Blood Transfusion	☐ Liver Disease	☐ Stroke	_____
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	_____
☐ Bruise Easily	☐ Lung Disease	☐ Thyroid Disease	_____
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Problems	_____
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	_____
☐ Blood Thinners	☐ Heart Attack/Failure	☐ Tumors or Growths	_____
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	_____
☐ Congenital Heart Disease	☐ Heart Pacemaker	☐ Radiation Treatments	_____
☐ Osteoporosis	☐ Heart Trouble/Disease	☐ Yellow Jaundice	_____

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: X_____ 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 of 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 service performed without previous financial arrangements, must be paid in full at the time services are rendered.

If you are unable to keep an appointment, please call at least 24 hours prior to that appointment. A fee of a minimum of $68 up to a maximum of $150 will be charged based on the appointment.

Patients who carry dental insurance understand that all dental services finished are charged directly to the patient and he or she, not the insurance company, is personally responsible for payment of all dental services. Your insurance policy is a pre-determined arrangement between your employer and the insurance company. We are not a party to that contract. **As a courtesy to our patients** this office will help prepare and submit the insurance forms for our patients and assist in making collections from insurance companies and will credit any such collections received to the patients' account. Any co-pay quoted from this office is an **estimate only**, not a guarantee of coverage. Unfortunately, insurance benefits will almost always be less than anticipated. It is your responsibility to contact your insurance to determine your particular benefits or requirements. 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 1.5 % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding 90 days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of 6 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 or ward by the dentist, I agree to pay, therefore, 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, **and I further agree to pay all costs, including 35% collection fee, court costs and reasonable attorney fees.** 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.

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 certify that I have read and understand 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 Witness