SALT LAKE FAMILY DENTAL
& ORTHODONTICS

Patient Information

Patient Name: _____ Birth Date: _____
FIRST MI LAST

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security #: _____ Driver's Lic. #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____
Street/PO Box Apt. or Unit #

_____
City ST Zip Code

E-mail Address: _____

Employer: _____

Preferred Method of Contact: ☐ Email ☐ Text ☐ Phone

Whom may we thank for referring you? Family /Friend Name: _____

☐ Insurance ☐ Location ☐ Event ☐ Mailer ☐ Internet ☐ Facebook ☐ Radio ☐ Phonebook

Responsible Party Information (if patient is a minor)

Name: _____ Birth Date: _____
FIRST MI LAST

Social Security #: _____ Driver's Lic. #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Health Information

Have you ever had any of the following? Please check those that apply:

☐AIDS/HIV Positive
☐Anemia
☐Artificial Joints
☐Asthma
☐Cancer
☐Chest Pain
☐Chronic/Bloody Cough
☐Diabetes
☐Drug Addiction
☐Epilepsy
☐Excessive Bleeding
☐Fainting/Dizziness
☐Fatigue
☐Glaucoma
☐Heart Disease
☐Hepatitis A / B / C
☐High Blood Pressure
☐Hoarseness
☐Kidney/Liver Disease
☐Loss of Appetite
☐Night Sweats
☐Osteoporosis
☐Pacemaker
☐Radiation Treatment
☐Respiratory Problems
☐Steroids
☐Snoring Problems
☐Sleep Apnea
☐TB
☐Unexplained Weight loss
☐Thyroid
☐Pregnant now?
Due Date: _____
☐Other: _____

Allergies:
☐Aspirin
☐Codeine
☐Erythromycin
☐Latex
☐Local Anesthetic
☐Penicillin
☐Sulfa
☐Other: _____

PREMED Y / N (circle one)

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Have you been hospitalized in the past 3 years? ☐ Yes ☐ No For What? _____
- Please list any current medications you are taking: _____
- Is there any other medical or dental information you feel I should know about? ☐ Yes ☐ No

Financial Policies

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connections with extension of credit, please be advised of the following policies which apply to our office:

1. The patient agrees to pay the doctor at the time that services are rendered or by previous arrangement.

2. Balances left unpaid beyond 30 days will be assessed a finance charge of 1½% per month (annual rate of 18% per year), with a minimum charge of $1.00 per month. Interest not paid when due shall be added to and become part of the principal.

3. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

4. There will be a $25.00 charge assessed on all returned checks.

5. Personal and joint credit may be checked.

6. There will be a $30.00 fee for missed appointments with less than 24 hours notice.

I certify that I have read, understood, and agree to the above policies.

_____ ___/___/___
Signature Date

Insurance Facts

1. Professional services are rendered to the patient and not to the insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

2. We are more than happy to help you by submitting your dental claims without any charge. Unfortunately, insurance benefits can be less than anticipated. Please understand that the amount of benefits to be derived under you particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that agreement.

3. For your convenience we will **estimate** the portion of you total fee that you insurance company will cover. This is **just an estimate**. After insurance benefits, you are responsible for any unpaid balance. We will ask you to cover the cost of the treatment that insurance company does not cost at the time that services are rendered.

I certify that I am covered by _____Insurance Co. and I assign directly to Dr. James Williamson all insurance benefits otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying my deductible and any co-payment that my insurance does not cover. I hereby authorize, Dr. Williamson to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic.

_____ ___/___/___
Signature Date

If yes, please explain: _____

DENTAL HISTORY

Please check any of the following that apply to you:

- -Sensitivity (hot, cold, sweet, biting) ☐
  Where? _____
- -Headaches, neck or jaw joint pain ☐
- -Mouth ulcers or cold sores ☐
- -Teeth or fillings breaking ☐
- -Grinding or clenching teeth ☐
- -Bleeding, swollen, irritated gums ☐
- -Loose, tipped or shifting teeth ☐
- -Bad breath ☐

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

- -Dentures ☐
- -Partial dentures ☐
- -Braces ☐
- -Gum treatments ☐

Please share the following dates:

- -Your last cleaning ___/___
- -Your last oral cancer screening ___/___
- -Your last complete x-rays ___/___

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

Why did you leave your previous dentist?

_____

	Y	N
If you could whiten your teeth for a cost you could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	Y	N
How much? _____For how long? _____	☐	☐

If you could change your smile, would you:

- -Whiten your teeth ☐
- -Straighten your teeth ☐
- -Close spaces ☐
- -Replace metal fillings with tooth colored fillings ☐
- -Repair chipped teeth ☐
- -Replace missing teeth ☐
- -Replace old crowns that don't match ☐
- -Have a smile makeover ☐

On a scale of 1–10; 10 being the highest

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

DENTAL INSURANCE INFORMATION (Primary)		
Insured's Name	DOB	SS#/ID
Insured's Employer		
Insurance Co		
Insurance Co Address		
Phone #		
Group #		

DENTAL INSURANCE INFORMATION (Secondary)		
Insured's Name	DOB	SS#/ID
Insured's Employer		
Insurance Co		
Insurance Co Address		
Phone #		
Group #		

I have reviewed the above information and give authorization to take x-rays, study models, photographs or any other diagnostic aids to make a thorough diagnosis of needs. I give authorization to perform agreed treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.

I authorize the use of any information necessary to process my insurance. I also authorize my insurance company(s) to issue the dental benefits of my plan directly to this office.

X_____ Date: _____
Signature of patient, parent or guardian

X_____ Date: _____
Doctor's Signature

_____
What Matters Most