FAMILY LEGACY DENTAL
PEDIATRIC AND FAMILY DENTISTRY

Patient Information

Date:_____

First Name:_____ MI:_____ Last Name:_____
DOB:_____ SSN:_____ Sex: M F DL/ID#:_____ State:_____
Home Phone:_____ Cell Phone:_____ E-Mail:_____
Address:_____ APT#:_____ City:_____ State:_____ Zip:_____
Employer:_____ Work Phone #:_____ Ext:_____
Spouse Name:_____ Spouse Phone #:_____

Responsible Party

Relation to Patient:_____
First Name:_____ MI:_____ Last Name:_____
DOB:_____ SSN:_____ Sex: M F DL/ID#:_____ State:_____
Home Phone:_____ Cell Phone:_____ E-Mail:_____
Address:_____ APT#:_____ City:_____ State:_____ Zip:_____
Employer:_____ Work Phone:_____ Ext:_____

Emergency Contacts

Contact # 1:_____ Relation:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____ Ext:_____
Contact # 2:_____ Relation:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____ Ext:_____

Primary Dental Insurance

Insurance Company:_____ Phone Number:_____
Policy #:_____ Group #:_____ Employer:_____
Policy Holder Name:_____ DOB:_____
Poliy Holder SSN:_____ Relation to Patient:_____

Secondary Dental Insurance

Insurance Company:_____ Phone Number:_____
Policy #:_____ Group #:_____ Employer:_____
Policy Holder Name:_____ DOB:_____
Poliy Holder SSN:_____ Relation to Patient:_____

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How did you hear about our Office?

o Internet	o Insurance Provider List	o Medicaid Provider List
o Facebook Page	o Mail Advertisement	o Hometown Values Magazine
o Valpak	o W.I.C.	o State of Utah

o Friend/Family (name) _____

o Other _____

Electronic Communication Consent

Name: _____ D.O.B.: _____

(Initial Below)

_____ AGREE

_____ DO NOT AGREE

That Family Legacy Dental may communicate with me electronically at the mobile phone number and/or E-mail address I have listed. I am aware that there is some level of risk involved in electronic communication and that third parties might be able to intercept the communications. I further agree that I am responsible for providing Family Legacy Dental with any updates for my electronic communication contact information. I understand that this consent can be withdrawn at any time by notifying Family Legacy Dental in writing.

Signature: _____ Date: _____

Acknowledgement of Review and Receipt of Notice of our Privacy Practices

Print Name: _____ Signature: _____ Date: _____

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Appointment Policy

(initial Below)

_____ Family Legacy Dental is dedicated to providing each of our patients with exceptional care. Every appointment in our office is reserved uniquely per each individual patient's needs. This reservation means that a specific length of time in the doctor's day is specifically dedicated for the patient whom is scheduled. Short notice appointment cancellations, missed appointments, and/or late arrivals to appointments, result in the inability to see another person, in possibly urgent need, at that appointment time. Thus, our Office Appointment Policy requires **48 BUSINESS HOURS for appointment changes or cancellations. Appointments that are changed or cancelled without notification of 48 business hours or late appointment arrival times, will result in a MISSED/CANCELED APPOINTMENT FEE of $75.00 per each appointment per hour of specifically reserved time for the appointment. If the appointment is cancelled within the 48 business hour mark you must provide payment at the time of cancelation or appointment change. Please note that the appointment will not be able to be rescheduled until that broken appointment fee is taken care of. Three missed or failed appointments, may result in dismissal from our office.**

Signature: _____ Date: _____

Financial Policy & Federal Truth-in-Lending Statement

(initial Below)

_____ As a condition of your treatment by this office, financial agreements must be made in advance. Patient copayments (the amount not covered by insurance) are due and payable at the time of service. All emergency dental services, or any dental services performed without previous financial agreements, must be paid for at the time services are rendered. As a courtesy, our office will submit claims of completed dental services to your insurance plan. It is the patient's responsibility to know and understand your dental insurance plan's provided benefits. Our office will do it's best to provide you with an estimated insurance coverage amount. The patient is financially responsible for payment in full for services rendered in the event their dental insurance pays less than originally estimated. Interest of 1.5% per month (18% annually) on all balances past due by 60 or more days will be assessed to accounts balances. A fee of 50% of my account balance will be added in the event my account is referred to a collection agency.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the state. 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 to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% of principle) that may be assessed by any collection agency retained to pursue this matter. I authorize all dental treatment claim payments entitled to the patient to be made directly to Family Legacy Dental.

Signature: _____ Date: _____

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Medical/Dental History

Patient Name: _____ D.O.B: _____

Primary Physician Name: _____ Physician Phone # _____

Medications: _____

Allergies: _____

Yes	No	
☐	☐	1. Are you having any dental pain or discomfort at this time?
☐	☐	2. Do you have now, or have you ever had bleeding or sensitive gums?
☐	☐	3. Do you feel nervous about having dental treatment?
☐	☐	4. Have you been under the care of a medical doctor during the past two years? (If yes) Physician's Name _____ Phone # _____
☐	☐	5. Have you ever had a bad reaction to dental anesthetic? (If yes, please explain) _____
☐	☐	6. Females: Are you, or could you possibly be, pregnant?
☐	☐	7. Have you ever been told that you need to be pre-medicated for dental treatment? (If yes, please explain) _____
☐	☐	8. Do you have pain in or near your ears?
☐	☐	9. Do you have any unhealed injuries or inflamed areas around your mouth?
☐	☐	10. Have you ever experienced any growth or sore spots in your mouth?
☐	☐	11. Does any part of your mouth hurt when your jaws are clenched?
☐	☐	12. Do you habitually clench your teeth during the day or night?

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Check any of the following which you have had or have at the present time

☐ Heart Murmur	☐ Kidney Disease	☐ Asthma	☐ Diabetes
☐ Rheumatic Fever	☐ Stroke	☐ Ulcers	☐ Arthritis
☐ Scarlet Fever	☐ Cancer	☐ Liver Disease	☐ Glaucoma
☐ Artificial Joints	☐ Low Blood Pressure	☐ High Blood Pressure	☐ Addiction
☐ Tuberculosis	☐ Hepatitis	☐ HIV/AIDS	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Psychiatric Disorder	☐ Bleeding Disorder	☐ Hay Fever
☐ Autism	☐ Cold Sores	☐ Anemia	☐ Other _____

I certify that I have answered all the questions on the form accurately and I hereby agree to abide by the conditions outlined therein.

Patient Name:_____ D.O.B: _____

Guardian Signature: _____ Date: _____

Updated:

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____