

Patient Information

Patient Name (last, first, MI) _____ Preferred Name _____ Date _____
Gender: _____ Married: _____ Single: _____ Age: _____
Social Security # _____ Date of birth _____
Phone (home) _____ (work) _____ ext. _____ (cell) _____
Email Address _____
Address _____
Street _____ Apartment # _____ City, State, Zip Code _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name (last, first, MI) _____ Male Female _____
Married Single Child Other _____
Social Security # _____ Date of birth _____
Phone (home) _____ (work) _____ ext. _____ Best time to call _____
Address _____
Street _____ Apartment # _____ City, State, Zip Code _____

Insurance Information

Primary Insurance

Name of insured _____ Is insured a covered patient? Yes No _____
Insured's birth date _____ ID # _____ Group # _____
Insured's address _____
Insured's employer name _____
Employer address _____
Relationship to patient self spouse child other _____
Insurance plan name and address _____

Secondary Insurance

Name of insured _____ Is insured a covered patient? Yes No _____
Insured's birth date _____ ID # _____ Group # _____
Insured's address _____
Insured's employer name _____
Employer address _____
Relationship to patient self spouse child other _____
Insurance plan name and address _____

* It is not easy for an office to become familiar with the details of every dental plan it encounters. And it is, of course, the responsibility of the patient not the dental office to know what is covered and what is excluded from her or his own dental plan. We will do our best to inform you of what we know of your dental plan but ultimately you are responsible for any and all charges not covered.

Signature _____ Date: _____

Health Information

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present time or have you been treated within the past year? If so, why? Yes No

2. When was your last dental checkup?

3. Have there been any changes to your general health in the past year? If yes, please explain. Yes No

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. Yes No

5. Do you have any allergies? If you answered yes, please list using the categories below: Yes No
 - a. Medications (please list)
 - b. latex/rubber products
 - c. other e.g. hayfever, foods
 - d. other (please explain)_____
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. Yes No

7. Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes No

8. Do you have a prosthetic or artificial joint? Yes No

9. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. Yes No

10. Do you have or have you ever had any of the following? Please check.

| | | | |
|------------------------|-------------------------|------------------------|------------------------------|
| AIDS | Drug/alcohol dependency | Kidney disease | Radiotherapy/steroid therapy |
| Anemia | Glaucoma | Leukemia | Rheumatic fever |
| Arthritis | Heart attack | Liver disease | Seizures (epilepsy) |
| Asthma | Heart disease | Lung disease | Sinus problems |
| Bleeding disorder | Heart murmur | Mental disorders | Stomach ulcers |
| Cancer | Hepatitis | Mitral valve prolapse | Stroke |
| Chemotherapy treatment | High blood pressure | Nervousness/Anxiety | Tuberculosis |
| Depression | HIV | Pacemaker | Thyroid disease |
| Diabetes | Jaundice | Prosthetic heart valve | Venereal disease |

Other (please explain)

11. Who is your primary care physician?

12. Are there any conditions or diseases not listed above that you have or have had? If so, what? Yes No

13. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) Yes No

14. Do you smoke or chew tobacco products? Yes No

15. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? Yes No

16. Are you nervous during dental treatment? Yes No

17. Rate your smile from 1 (poor) to 10 (excellent).

18. If you could change anything about your smile, what would it be?

19. What are your hobbies or interests?

20. What do you do for work?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date

Referral Information

Whom may we thank for referring you to our practice? another patient, friend another patient, relative

Dental office Yellow pages Newspaper School Work Other _____

Name of person or office referring you to our practice _____

Consent for Services

As a condition of my treatment by this office, payment is expected in full at time of service. If financial arrangements are necessary they must be made in advance. The practice depends upon reimbursement from me for the costs incurred in my care and financial responsibility on my part must be determined before treatment.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. If I carry dental insurance I understand that all dental services furnished are charged directly to me and that I am personally responsible for payment of all dental services. This office will help prepare insurance claims or assist in making collections from insurance companies and will credit any such collections to my account. However, this dental office cannot render services on the assumption that my charges will be paid by an insurance company.

I agree that interest will accrue on all past-due amounts over 30 days at the rate of 18% per annum (1.5% per month) until paid in full.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. 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 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, see, 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

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 in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have been given the opportunity to receive a copy of Dr. Jared W. Hemmert's Notice of Privacy Practices. I have also had a chance to review the Notice of Privacy Practices in the office. I understand that Personal Health Information may be used and disclosed for treatment, payment, or healthcare operations. I understand that I have the right to review Dr. Jared W. Hemmert's privacy Notice at any time. I have a right to request restrictions and/or revoke consent in writing if agreed to by Dr. Jared W. Hemmert. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions in this form accurately and to the best of my knowledge. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date

Relationship to patient

Signature of guarantor of payment/responsible party

Date

Relationship to patient