WELCOME! So that we may provide you with the best possible care, Please complete all sections of this medical/dental history form. All information is held completely confidential.

PATIENT INFORMATION

Patient Name:_______________________________ Sex:________ Birthdate:________________________

Legal Guardian: ____ Relation:____________________________

Mailing Address:____ Email: _________________________
Address City Zip

Home Phone:_____________________ Cell Phone:_________________________ Work Phone:____________________________

Social Security #:______________________________ Marital Status: Married Single Divorced Separated Widowed Child

Place of Employment: _________________________________ Nearest Relative name and #:_________________________________

DENTAL INSURANCE

Primary Insurance Co.:____ ID#:______________________________
Insured Name: ____SS#:___________________________ Birthdate:_________________
Place of Employment: ____ Group #: _____________________

Secondary Insurance Co.: ____ ID#: _______________________________
Insured Name: ____ SS#: _________________________ Birthdate: ________________
Place of Employment:____ Group #: ____________________

THE FACTS ABOUT INSURANCE AND OUR FINANCIAL POLICY

Please understand we are desirous to extend care to you and to work with you on any insurance coverage you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE

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

2: Unfortunately, insurance benefits will almost always be less then anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that with this agreement.

3: For your convenience we will ESTIMATE the portion of your total fee that your insurance company will cover. This is JUST AN ESTIMATE. After insurance benefit, you are responsible for ANY UNPAID BALANCE. We will ask you to bring with you at the time of treatment the ESTIMATED uncovered portion of the total fee.

4: A finance charge of 1.5% per month will be added to your bill if payment has not been received with in 60 days. This will allow adequate time for you to see that your insurance benefits have been paid. There is a $15.00 Late Fee for payments paid after the 1st of the month.

5: Our policy requires a percentage of the fee to be paid at the time of service, if patient has dental insurance. Full payment is required at time of service if there is no insurance. Payment options are: Cash – Check – Visa – MasterCard – Discover – American Express – CareCredit

6: By signing below I agree to pay all amount(s) owed with in 30 days of when such amounts are incurred. 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, I agree that it is my responsibility to pay all amounts owing. I agree that intrest will accrue on all past due amounts at the rate of 1.5% a month until paid in full. In the event any amount is referred to a third party collection agency, I agree that in addition to any other amounts allowed for by law, (such as intrest, court cost, reasonable attorney fees.) I will also be responsible for a collection fee of up to 40% of the principal amount owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after.
Thank you for your understanding in this matter.

____

Signature Date

DENTAL HISTORY

Reason for this visit: ______________________________ Date of last dental Visit: ______________

When was your last dental cleaning? ______________ Have you been treated for Periodontal Disease? __________

Who is your Orthodontist? ______________________________ Phone Number: ____________________

Are any of your teeth sensitive to:		Are you satisfied with your teeth's appearance?	Yes No
Hot or Cold?	Yes No	Would you like to keep all of your teeth?	Yes No
Sweets?	Yes No	Would you like to Brighten your smile?	Yes No
Biting or Chewing?	Yes No	Do your Gums bleed or hurt?	Yes No
Bad Odors or Bad Breath?	Yes No	Do have a Dental Fear?	Yes No

Is there anything else about having dental treatment that you would like us to know? ____________________
____

MEDICAL HISTORY

Circle any of the following which you have had or ever had:
Arthritis ~ Asthma ~ Bleeding Problems ~ Kidney Problems ~ High or Low Blood Pressure ~ Heart Murmur ~ Rheumatic Fever ~ Phen-Fen ~ Diabetes ~ Cancer ~ Epilepsy/Seizure ~ Stroke ~ Hepatitis A - B – C ~ Tuberculosis ~ Venereal Disease ~ H.I.V + ~ Herpes/Cold Sores ~ Joint Replacement ~ Seasonal allergies ~ Heart Disease ~ Artificial Heart Valve ~ Pacemaker ~ A.I.D.S

Are you allergic to any drugs such as Amoxicillin, pain medications, aspirin or codeine? Yes No
If yes what are they? :____

Are you allergic to LATEX? Yes No

- Please list any medications you are currently taking: ______________________________

Are you taking any of the following medications: Novartis, Aredia, Zometa, Bonefos, Boniva, Didoronel, Noniva, Actonel, Fosamax ~ No

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ 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: ______________

Female Patients: Are you pregnant? Y N Due Date:__________________

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

HIPPA CONSENT

By signing this consent, you are granting Dr. W. Michael Black D.D.S. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our notice of Privacy Practice provides more detailed information about how we may use and disclose this protected health information. You have legal right to review this notice before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the changes. You have the right to request how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do agree we our bound by are agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health or insurance information in reliance on your consent.

____

Print Name Signature Date

HOW DID YOU HEAR ABOUT OUR DENTAL OFFICE? ______________________________