# WELCOME

## ABOUT YOU

**Today's Date**:_____

**Name:**_____

I prefer to be called: _____ □**Male** □**Female**

**Birth-date:** ____/____/_____**Age:**___**SS#**_____

### CONTACT INFORMATION

**Home #**_____**Work #**_____

**Cell #**_____**Other #**_____

**Dr Lic #**_____**State**_____

**Home Address:**_____

**City**_____**State**_____**Zip**_____

**Mailing Address:**_____

**City**_____**State**_____**Zip**_____

**Email:**_____

□ **Single** □ **Married** □ **Divorced** □ **Widowed**

**Spouse:**_____**Phone#**_____

### OTHER INFORMATION

**Who may we Thank for referring you?**_____

**Emergency Contact:**_____

**Relationship**_____**Phone#**_____

**Other family members seen by us?**_____

**Previous Dentist:**_____**Last Visit**_____

## YOUR EMPLOYMENT

**Employer:**_____

**Address:**_____**Phone#**_____

**Occupation:**_____**How long?**_____

## ACCOUNT RESPONSIBILITY

**Name of Responsible Person:**_____

**Birth-date:**____ /____/_____**SS#**_____

**Employer**_____

**Relationship:**_____**Phone#**_____

**Address:**_____

**City**_____**State**_____**Zip**_____

## DENTAL INSURANCE

IF DENTAL INSURANCE WILL BE INVOLVED,

PLEASE COMPLETE INFORMATION BELOW

### PRIMARY DENTAL INSURANCE

(Use your Identification Card)

**Subscriber name:**_____

**Insured's Birthday** ___/____/_____**SS#**_____

**Insured's Employer:**_____

**Insurance Co. Name:**_____

**Insurance Co. Phone #**_____

**Group #**_____

**Member ID #**_____

### SECONDARY DENTAL INSURANCE

(Use your Identification Card)

**Insured's Name:**_____

**Insured's Birthday** ___/____/_____**SS#**_____

**Insured's Employer:**_____

**Insurance Co. Name:**_____

**Insurance Co. Phone #**_____

**Group #**_____

**Member ID #**_____

## RELEASE OF INFORMATION

I authorize release of information relating to any insurance claim, to my insurance company. I understand that I am responsible for all costs of dental treatment.

**Signed:**_____**Date:**_____

## PAYMENT AUTHORIZATION

I hereby authorize payment directly to the below named dentist or the group insurance benefits otherwise payable to me.

**Dr. Dan Utley DDS, Dr. Tyler Utley and/or Associates**

**Signed:**_____**Date:**_____

## MISSED APPOINTMENT

NOTICE: THERE **MAY** BE A CHARGE FOR BROKEN OR MISSED APPOINTMENTS WITHOUT 48 HOUR NOTICE.

# HEALTH HISTORY

## CURRENT INFORMATION

**Patient Name:**_____

**Do you have a personal Physician?** YES or NO

**Physician's Name:**_____

**Phone #**_____**Last Visit**_____

**Are you currently under the care of a physician?** YES or NO

**If yes, Please explain**_____

**Are you taking any prescription/over-the-counter drugs?**

YES or NO Please list each one:_____

_____

## MEDICAL HISTORY

**HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?**

| | | |
|---|---|---|
| **Y / N** Aids | **Y / N** Excessive Bleeding | **Y / N** Multiple Scleroses |
| **Y / N** Allergies (SEE LIST TOP RIGHT) | **Y / N** Fainting | **Y / N** Pacemaker |
| **Y / N** Anemia | **Y / N** Fever Blisters | **Y / N** Radiation Treatment |
| **Y / N** Arthritis | **Y / N** Glaucoma | **Y / N** Respiratory Problems |
| **Y / N** Artificial Joints | **Y / N** Growths | **Y / N** Rheumatic Fever |
| **Y / N** Artificial Valves | **Y / N** Hay Fever | **Y / N** Rheumatism |
| **Y / N** Asthma | **Y / N** Heart Attack | **Y / N** Sinus Problems |
| **Y / N** Blood Disease | **Y / N** Heart Arrhythmia | **Y / N** Stomach Problems |
| **Y / N** Cancer | **Y / N** Heart Disease | **Y / N** Stroke |
| **Y / N** Cold Sores | **Y / N** High Blood Pressure | **Y / N** Tuberculosis |
| **Y / N** Congenial Heart | **Y / N** Kidney Disease | **Y / N** Tumors |
| **Y / N** Diabetes | **Y / N** Liver Disease | **Y / N** Ulcers |
| **Y / N** Dizziness | **Y / N** Mental Disorders | **Y / N** Venereal Disease |
| **Y / N** Drug/Alcohol Abuse | **Y / N** Mitral Value Prolapse | |
| **Y / N** Epilepsy | | |

**Please list any serious medical condition(s) that you have ever had which are not on list.** _____

_____

_____

_____

_____

## FOR WOMEN

**Are you taking birth control?** YES or NO

**Are you pregnant?** YES or NO Week #_____

**Are you nursing?** YES or NO

## ALLERGIES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS?

| | | | |
|---|---|---|---|
| **Y / N** Amoxicillin | **Y / N** Darvon | **Y / N** Epinephrine | **Y / N** Nitrous |
| **Y / N** Aspirin | **Y / N** Demerol | **Y / N** Ibuprofen | **Y / N** Penicillin |
| **Y / N** Ceclor | **Y / N** Dental Anesthetics | **Y / N** Keflex | **Y / N** Sulfa Drugs |
| **Y / N** Codeine | **Y / N** Erythromycin | **Y / N** Latex | **Y / N** Tetracycline |

Other_____

_____

_____

## CURRENT ORAL HEALTH

PLEASE ANSWER ALL OF THE QUESTIONS TO HELP US SERVE YOU TO THE BEST OF OUR ABILITIES

**How long ago was your last dental visit?**_____

**Do you have or have you ever had bleeding or sensitive gums?**

_____

**Have you ever used or are you now using tobacco or alcohol?**

_____**Frequency**_____

**Please outline your Brushing/Flossing habits**_____

_____

### HEALTH QUESTIONNAIRE ACKNOWLEDGMENT

I CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signed:_____Date:_____

## CONSENT TO PROCEED

I authorize Dr. Utley and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative analgesic, (including nitrous oxide,) therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

I do voluntarily assume any and all possible risk, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature:_____Date:_____

Witness:_____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 for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.**

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

**Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy, this office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.**

**A monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.**

**In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. 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. 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 must request the office Privacy Policy and that I have received a copy of this office's Privacy Policy upon my request. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care. I acknowledge there is an authorization form I must sign.**

**I certify that I have answered all questions on the Welcome and Health History forms 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**

_____

**Print Name**

**Relationship to patient: _____**

*The interest rate charged may be at the discretion of this office or office accountant.

# Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize *50th and France Dental Care* to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

## Authorization to Leave Detailed Messages

Occasionally it is necessary for the staff of *50th and France Dental Care* to leave messages for patients. The purpose of these messages are to notify the patient that we would like to discuss treatment needs, billing purposes or to ask a patient to call back regarding an issue or concern. To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages.

**Please mark your preference below:**

_____ I authorize *50th and France Dental Care* to leave detailed voicemails.

This is the phone # I would like messages left: _____

_____ I authorize *50th and France Dental Care* to send detailed emails.

This is the email address I would like messages sent: _____

_____ I do not want any detailed messages left on voicemail or sent via email.

**Patient Information**

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above authorized recipient or voicemail or email is no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail or email.

You have the right to revoke this consent in writing.

Signature:_____Date:_____