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PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	PREFERRED NAME	DATE

DATE OF BIRTH	GENDER	SSN	MARITAL STATUS
	☐ M ☐ F		☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER: _____

HOME PHONE	CELL PHONE	WORK PHONE	EXTENSION

EMAIL ADDRESS	COMMUNICATION PREFERENCE FOR CLINICAL INFORMATION (SELECT ONE)
	☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ EMAIL ☐ MAIL

HOME STREET ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE

OCCUPATION	EMPLOYER	EMPLOYER PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

NAME OF PERSON WHO REFERRED YOU TO US	OTHER REFERRAL SOURCE
	☐ INSURANCE CO. ☐ MAILER ☐ DRIVE-BY ☐ WEBSITE ☐ OTHER:

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

FIRST NAME	MI	LAST NAME	RELATIONSHIP TO PATIENT

DATE OF BIRTH	GENDER	SSN	DRIVER'S LICENSE #	STATE
	☐ M ☐ F			

HOME PHONE	CELL PHONE	WORK PHONE	EXTENSION

EMAIL ADDRESS	PREFFERRED PHARMACY	PHARMACY PHONE

HOME STREET ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE

OCCUPATION/POSITION	HOW LONG?	EMPLOYER	EMPLOYER PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

PRIMARY INSURANCE ☐ INSURANCE CARD PROVIDED

SUBSCRIBER FIRST NAME	SUBSCRIBER LAST NAME

DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED
	☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT

INSURANCE COMPANY	INSURED'S SSN

INSURANCE COMPANY ADDRESS	STATE	ZIP CODE

EMPLOYER

GROUP #	POLICY #

GROUP NAME	POLICY EFFECTIVE DATE

SECONDARY INSURANCE ☐ INSURANCE CARD PROVIDED

SUBSCRIBER FIRST NAME	SUBSCRIBER LAST NAME

DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED
	☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT

INSURANCE COMPANY	INSURED'S SSN

INSURANCE COMPANY ADDRESS	STATE	ZIP CODE

EMPLOYER

GROUP #	POLICY #

GROUP NAME	POLICY EFFECTIVE DATE

I verify that the above information is true and correct.

Signature: _____ *Date:* _____

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Patient Name: _____ Date of last dental visit: _____

Reason for today's visit: _____

DENTAL HEALTH

Please check any of the following that apply to your mouth:

- ☐ Acid Reflux
- ☐ Antibiotic Premedication for dental tx
- ☐ Bad Breath
- ☐ Burning mouth/tongue
- ☐ Cankers
- ☐ Cold Sores
- ☐ Clench or Grind Teeth
- ☐ Dry Mouth
- ☐ Gums sollen, tender or bleeding
- ☐ Jaw pain
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure
- ☐ Tobacco Use Type: _____ Frequency: _____

How often do you brush? _____ Floss? _____

Have you ever had a reaction to dental anestheic? ☐ Yes ☐ No

Explain: _____

MEDICAL HISTORY

Please select yes or no, if the following conditions apply, or have ever applied to you:

- ☐ Yes ☐ No Allergies
- ☐ Yes ☐ No Aspirin
- ☐ Yes ☐ No Codeine/Narcotics
- ☐ Yes ☐ No Dental Anesthetic
- ☐ Yes ☐ No Iodine
- ☐ Yes ☐ No Latex
- ☐ Yes ☐ No Metals/Nickels/Jewelry
- ☐ Yes ☐ No Penicillin or Amoxicillin
- ☐ Yes ☐ No Sulfa Drugs

Other:_____

Cardiovascular Health

- ☐ Yes ☐ No Angina or Heart Attack
- ☐ Yes ☐ No Coronary Bypass
- ☐ Yes ☐ No Heart Disease or treatment
- ☐ Yes ☐ No Heart valve problem/replacement
- ☐ Yes ☐ No Heart Murmur
- ☐ Yes ☐ No Congenital
- ☐ Yes ☐ No High Blood Pressure
- ☐ Yes ☐ No Irregular Heartbeat/Pacemaker
- ☐ Yes ☐ No Low Blood Pressure
- ☐ Yes ☐ No Past use of Phen-Fen
- ☐ Yes ☐ No Rheumatic Fever
- ☐ Yes ☐ No Stroke

Endocrine/Blood/Immune Health

- ☐ Yes ☐ No Abnormal Bleeding/Bruising
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Blood transfusion
- ☐ Yes ☐ No Cancer

Type:_____

- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Hemophilia
- ☐ Yes ☐ No HIV Infection/AIDS
- ☐ Yes ☐ No Lupus
- ☐ Yes ☐ No Organ transplant
- ☐ Yes ☐ No Rhuematiod Arthritis
- ☐ Yes ☐ No Thyroid Problems

GI/Urinary Health

- ☐ Yes ☐ No Crohn's Disease
- ☐ Yes ☐ No Hepatitis Type: _____
- ☐ Yes ☐ No Kidney disease/Dialysis
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Ulcers
- ☐ Yes ☐ No Ulcerative Colitis
- ☐ Yes ☐ No Sexually Transmitted Disease

Are you currently under the care of a physician? ☐ Yes ☐ No

Name of Physician: _____

Muscular-Skeleton/CNS/Mental Health

- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Anxiety/Nervousness
- ☐ Yes ☐ No Dementia/Alzheimer's
- ☐ Yes ☐ No Depression/Bi-polar Disorder
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Faining/Dizziness
- ☐ Yes ☐ No History of Alcohol or Drug Abuse
- ☐ Yes ☐ No Joint Replacement
- ☐ Yes ☐ No Mental Health Treatment
- ☐ Yes ☐ No Multiple Sclerosis
- ☐ Yes ☐ No Osteoporosis
- ☐ Yes ☐ No Schizophrenia
- ☐ Yes ☐ No Seizures

Repiratory Health

- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No COPD
- ☐ Yes ☐ No Chronic Sinus Problems
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No Hay Fever
- ☐ Yes ☐ No Tuberculosis

List all medications you are currently taking

Medication:_____ Condition:_____

Medication:_____ Condition:_____

Medication:_____ Condition:_____

Medication:_____ Condition:_____

Women

Are you currently:

Nursing: ☐ Yes ☐ No

Pregnant: ☐ Yes ☐ No

Taking Birth control pills: ☐ Yes ☐ No

I have answered all health questions to the best of my knowledge.

Signature: _____ *Date:* _____

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3473 W. South Jordan Parkway #2 • South Jordan, UT 84095 • 801-260-9150

OFFICE POLICIES

All Patients must complete all forms before being seen by a healthcare professional.

Late/Missed Appointments

- You may be asked to reschedule if you arrive more than 10 minutes late.
- There is a $25/hr fee levied on appointments missed with less than 24 hour cancellation notice.

Unaccompanied Minors

- Unaccompanied minors must have any applicable forms filled out by a parent or guardian BEFORE they can be seen in our office for ANY treatment! Payment is still due at time of service for these patients.

Insurance/Payment Policy

- Our office will bill your dental insurance, but it is your responsibility to know limitation and coverage benefits of any applicable insurance plan. All fees for services rendered, are the responsibility of the guarantor/responsible party, whether insurance coverage is active or not.
- Full payment is due at the time of service.
- We accept cash, checks, Amex, Visa, Mastercard, Discover and Care Credit
- Our office does not accept Medicaid or CHIP Insurance.
- Delinquent Payments will be turned over to a collection agency after 90 days of inactivity.
- If your account is turned over to Collections, you will be dismissed from the practice.

CONSENT FOR SERVICES/FINANCIAL AGREEMENT

The information collected in this questionnaire is for the purpose of providing treatment to you. Personal information is used to contact you, process payments and verify insurance coverage. We may disclose your personal health information to other health care professionals, collection agencies and their affiliates if necessary; or require it from other providers as necessary for your treatment in our office. You may request copies of your records and xrays at any time. Disclosure of any personal information will not be made to any person not involved in your treatment or to the administrators of this practice, without your prior written consent. By providing your email and phone information you consent to our office and our affiliates to contact you via these methods. If you have any questions about our handling of your health information, please do not hesitate to raise these concerns with our practice. More information is available at your request.

Services rendered are charged directly to the patient and the patient or responsible party (if designated) is responsible for payment of all services rendered. As a courtesy, we will submit forms to insurance, if applicable, if you provide accurate insurance information to our office. However, it is the patient's responsibility to know their personal insurance benefits and coverage, not our office's. We cannot guarantee payment of any claim, and any estimate we provide for treatment, is merely an estimate. It is your responsibility to be familiar with your insurance limitations, coverage and any applicable downgrades. All outstanding balances not paid by insurance will be billed directly to the patient/responsible party. Estimated portion or payment in full is due at the time of service. Payment arrangements must be made in advance. You will be provided a separate form detailing any payment arrangements, if necessary. Our office does not render any service on the assumption that the charges will be paid by insurance. I agree that if payment cannot be made at the time of service, treatment may be denied and I am responsible for any damages incurred. I agree to pay any court costs and attorney fees with or without suit, incurred in collecting any past due balance, and a collection fee up to 40% of the outstanding balance owed, as compensation to sojo dental, or its affiliates, for any commission that it must pay to a collection agency in collecting any outstanding balance. Furthermore, I agree that this fee is proportionate to the actual damage caused by my nonpayment and is not an excessive amount of collection costs. There is a returned check fee of $25.

I, _____ *(Please print name)*
have read the above office policies, conditions of treatment and payment, and agree to their content.

Signature of Responsible Party _____

Date _____ *Relation to patient* _____