TOOELE DENTAL
FAMILY & IMPLANT DENTISTRY

668 N Garden St, Tooele, UT 84074

PATIENT

Name _____
(First) (Last)
Mr. Mrs. Ms. Dr. Preferred Name _____

Birth date _____SS#_____-_____-_____

Home Address _____

City _____State _____ Zip _____

Minor Single Married Divorced Widowed Separated

Home # _____ Cell # _____

Work # _____ Other # _____

Email _____

Driver's License Number _____ State _____

Who may we thank for referring you? _____

Other family members seen by us? _____

EMERGENCY CONTACT

In the event of an emergency, who should we contact?

Name _____ Relationship _____

Home # _____ Cell # _____

Work # _____ Other # _____

FINANCIAL RESPONIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 45 days past due, a monthly service charge at a fixed rate of 1.5% per month/18% per annum (or the maximum allowable rate) of the unpaid balance as of the last day of each month will be assessed and added to the balance from the date of service unless previously written financial arrangements are made. There will be a $25.00 charge for returned checks.

I have read and understand the above financial responsibility:

Signature _____ Date _____

DENTAL INSURANCE

Primary Dental Insurance

Subscriber's Name _____

Birth date _____ SS# _____-_____-_____

Name of Insurance Co. _____

Policy ID # _____

Group # _____

Employer _____

Insurance Phone # _____

Secondary Dental Insurance

Subscriber's Name _____

Birth date _____SS# _____-_____-_____

Name of Insurance Co. _____

Policy ID # _____

Group # _____

Employer _____

Insurance Phone # _____

INSURED PATIENTS NOTICE

It is the patient's responsibility to verify coverage and eligibility with insurance carrier prior to service. Insurance is a contract between the patient and insurance company. Tooele Dental Associates bills insurance companies as a courtesy, but this is not a guarantee of payment. All price quotes are an estimate of what your insurance company might pay. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any remaining balance.

I have read and understand the above patient notice:

Signature _____ Date _____

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MEDICAL HISTORY

Have you ever had any of the following disease or medical problems?

Abnormal Bleeding	Y	N	Fainting / Dizziness	Y	N	Low Blood Pressure	Y	N
Alcohol / Drug Abuse	Y	N	Frequent Headaches	Y	N	Mitral Valve Prolapse	Y	N
Anemia	Y	N	Glaucoma	Y	N	Nervous Problems	Y	N
Arthritis	Y	N	Heart Problems	Y	N	Pace Maker	Y	N
Artificial Joints / Bones	Y	N	Heart Attack date_____	Y	N	Radiation Treatment	Y	N
Artificial Heart Valves	Y	N	Heart Surgery	Y	N	Rheumatic / Scarlet Fever	Y	N
Asthma	Y	N	Hemophilia	Y	N	Seizures	Y	N
Back Problems	Y	N	Hepatitis (circle) A B C	Y	N	Stroke	Y	N
Taking Blood Thinners	Y	N	Herpes / Cold Sores	Y	N	Thyroid Problems	Y	N
Cancer/ Chemo Treatment	Y	N	High Blood Pressure	Y	N	Ulcers	Y	N
Diabetic (circle) I II	Y	N	HIV / AIDS	Y	N	Tobacco Use	Y	N

Other relevant medical conditions: _____

ALLERGIES

Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin	Y	N
Latex	Y	N	Tetracycline	Y	N	Pain Medication	Y	N
Codeine	Y	N	Erythromycin	Y	N	Other (Please List)	Y	N

Other known allergies: _____

Are you currently under the care of a physician for a medical condition? **Yes / No**

If yes, please list the reason: _____

Are you currently taking any **medication**(s)? (Prescription or over the counter) **Yes / No**

If yes, please list: _____

Describe your current physical health: **Excellent** **Fair** **Poor**

Has your physician prescribed a pre-medication for an artificial joint or other medical condition? **Yes / No**

WOMEN ONLY

Are you pregnant? **Yes / No** If so, when are you due? _____

Are you nursing? **Yes / No**

Are you taking birth control? **Yes / No** If so, what is the name? _____

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CONSENT TO RELEASE PHOTOGRAPHS, IMAGES, AND/OR RADIOGRAPHS

(You may refuse to sign this acknowledgment)

I authorized any photographs to be taken of me before, during, or after treatment at Tooele Dental Associates to be used for educational purpose, laboratory fabrication, or internal office use. I fully understand that other dentists and team members may view these photos for educational and/or treatment purposes. No photos will be shared on social media or online without a patient's written consent.

Signature _____ Date _____

ACKNOWLEGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

(Notice of Privacy Practices are attached to the clip board)

I have read the in office copy of Tooele Dental Associates's Notice of Privacy Practices, attached to this clipboard and acknowledge that I understand what I have read. I also understand that I may request a copy for my records.

Signature _____ Date _____

For In Office Use Only

We attempted to obtain written acknowledgment of receipt of Privacy Practices, but acknowledgment could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgment
- □ Other: _____

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CONSENT TO PROCEED

I authorize **Dr. Brett Wells, Dr. Michael Wells, and/or such associates or assistants** as s/he 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 (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, 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, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, 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 _____
(Patient/Legal Guardian)

Witness Signature _____ Date _____

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FINANCIAL POLICY

This is an arrangement between Tooele Dental Associates and the Patient/Guarantor. The word Guarantor refers to the responsible party. Signing this policy determines you as the Guarantor. The word account means the account that has been established in your name to which the charges are made and payments credited. The words 'we' and 'our' refer to Tooele Dental Associates. By executing the agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a statement. It will reflect a previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Payment Options if you have no insurance: **Payment is expected in full on the day that treatment is rendered.** You may pay cash, check or credit/debit card. You may prefer to secure financing through a third party such as CareCredit. If you would like more information on this please ask.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. In order to properly bill your insurance we require that you disclose all insurance. Failure to provide complete insurance information may result in the patient responsibility for the entire bill. Tooele Dental Associates will bill your insurance; however, it is NOT a guarantee of payment. Although we may **estimate** what your insurance company might pay, it is the insurance company that makes the final determination of your eligibility and benefits. Insurance companies provide an Explanation of Benefits outlining payments and patient balances. I understand that the fee estimate listed for dental care can only be extended for a period of six (6) months from the date of the patient examination.

Payment Options if you have insurance: You will need to pay your deductible, co-payment, and any out-of-pocket portions **at the time of service** by cash, check, or credit card. If you choose to pay for all of your treatment in full at the time of service, we will promptly issue a refund for any credit balance. **It is your responsibility to verify coverage and eligibility with your insurance carrier prior to service.**

Payments: Unless we approve other arrangements in writing, the balance on your statement is due upon receipt. If payment is not received, **we reserve the right to refuse future appointments on delinquent accounts**.
Any balance remaining after your insurance coverage is collected, for whatever reason, is your responsibility. Full payment is due upon receiving your statement from Tooele Dental Associates unless prior arrangements have been made.

Returned Checks: There is a **$25.00 returned check fee** on any checks returned by the bank. We may choose to proceed with legal action which could result in additional fees to the patient or guarantor on the account.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we refer the collection of the balance to a lawyer, you agree to pay all lawyers' fees that we incur plus court costs.

Interest Charges: A monthly service charge at a fixed rate of 1.5% per month/18% per annum (or the maximum allowable rate at the time) of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding forty-five (45) days from the date of service unless previously written financial arrangements are made.

Missed/Cancelled Appointments: A **$58.00 fee** will be added to your account, each hour scheduled, for appointment cancellations that do not give our office a 24 hour notice.

Signature _____ Date _____
(Patient/Legal Guardian)

Witness Signature _____ Date _____

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PATIENT PRIVACY PRACTICES

I understand that I the certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

-Treatment (including or indirect treatment by other healthcare providers involved in my treatment).

-Obtaining payment from the third-party payer (e.g., my insurance company).

-The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure of a copy of your Notice of Privacy Practices, which contains a more complete description of HIPPA. I understand that you reserve the right to change the terms of this notice from time to time that I may contact you at any time to obtain the most currant copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations but that you are not required to agree to these requested restrictions. However, if you do not agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to date I revoke this consent is not affected.