FORT UNION
family dental

Patient Information

Please print all information in the spaces provided. Be sure to complete and sign the statement on the back of this form.

Last Name _____ First Name _____ M.I. _____
Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ Married ___ Single ___ Other ___
Cell Phone ( ) _____ - _____ Home Phone ( ) _____ - _____ Work Phone ( ) _____ - _____
Email _____@_____
Address _____Apt #____ City _____ State _____ Zip _____
Spouse Name _____ Cell Phone ( ) _____ - _____
Employer Name _____ Employer Address _____
Who Referred you to our office? _____

Primary Insurance

Insurance Company: Name _____ Phone Number ( ) _____ - _____
Billing Address _____
Subscriber: Name _____ Relation to Patient _____
Date of Birth _____/_____/_____ ID Number _____ Group Number _____

Secondary Insurance

Insurance Company: Name _____ Phone Number ( ) _____ - _____
Billing Address _____
Subscriber: Name _____ Relation to Patient _____
Date of Birth _____/_____/_____ ID Number _____ Group Number _____

Person to contact in the case of an emergency _____ Phone Number ( ) _____ - _____

I hereby accept responsibility for payment of any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the practice does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

Missed Appointment Policy
I understand that there is a $50 fee for a missed appointment with less than 24-hour notice.

_____ _____
Signature of patient or guardian Date

Patient Information

Please answer all of the YES or NO questions and provide answers where applicable:

Physician Name _____ Phone _____

Yes No

1. Do you consider yourself to be in good health? ☐ ☐
2. Are you now or have you been under a physician's care within the past year? ☐ ☐
   If yes, specify condition being treated _____ ☐ ☐
3. Do you take medications? (Women: including birth control) ☐ ☐
   Please specify name and purpose of medications: (if you have a list with you, we can put a copy to your chart instead)
   _____
4. Do you have or have you ever had any heart problems? ☐ ☐
   If yes; please specify _____
5. Do you require antibiotic pre-medication for a heart condition, artificial valve or joint? ☐ ☐
6. Do you have or have you ever had high blood pressure? ☐ ☐
7. Do you bruise or bleed easily? ☐ ☐
8. Have you ever been diagnosed as being HIV positive or having AIDS? ☐ ☐
9. Have you ever had hepatitis or liver disease? ☐ ☐
10. Do you have an auto-immune disease? ☐ ☐
11. Have you ever had?

Y/N	Y/N	Y/N	Y/N
☐☐ Rheumatic Fever	☐☐ Asthma	☐☐ Blood disorders	☐☐ Diabetes
☐☐ Arthritis tuberculosis	☐☐ Venereal disease	☐☐ Heart attack	☐☐ Kidney disease

If yes, please specify: _____

12. Have you ever had an unusual reaction or are allergic to any of the following drugs:

Y/N	Y/N	Y/N	Y/N
☐☐ Penicillin	☐☐ Aspirin	☐☐ Acetaminophen	☐☐ Ibuprofen
☐☐ Codeine	☐☐ Barbiturates	☐☐ Sulfa Drugs	☐☐ Other_____

13. Are you subject to fainting? ☐ ☐
14. Are you allergic to Latex? ☐ ☐
15. Are you allergic to any local anesthetic? ☐ ☐
16. Do you have any other allergies? If yes, please describe: _____ ☐ ☐
17. Have you ever had a nervous breakdown? ☐ ☐
18. Have you ever received counseling for use of alcohol or prescription drugs? ☐ ☐
19. **Women**: Are you pregnant? If yes, how far along? _____ ☐ ☐
20. Are you now in pain? ☐ ☐
21. How long ago did you last see a dentist? ☐ ☐
22. Do you think that your teeth are affecting your general health in any way? ☐ ☐
23. Do you have or have you ever had bleeding or sensitive gums? ☐ ☐
24. Have you ever taken Phen-Fen or similar appetite suppressants? ☐ ☐
25. Have you used; Alcohol ☐ Tobacco ☐ Smoke ☐ Chew ☐ Vape ☐ **PAST** ☐ **STOP date**: _____
26. Have you ever taken Fosamax, Actonel, Boniva, or any other drug prescribed to decrease the resorption of bone as in osteoporosis or ay drugs for metastatic bone cancer? ☐ ☐

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

_____ _____

Signature of patient or guardian Date

FORT UNION
family dental

Written Financial Policy

To our valued patients, thank you for choosing Fort Union Family Dental. We want your experience with us to be as pleasant and pain-free as possible. Even when it comes to finances! We feel that communication is the best way to avoid problems and hope this information is helpful. Here are our flexible payment options.

You can choose from:
1) Cash, Check, or Credit Card
2) Convenient Monthly Payment Options from CareCredit and/or Lending Club both offering zero-interest financing options.
3) Flexible in-office payment options available with default interest of 18% APR.
4) For patients without insurance we have an in-office discount plan available called the Smile Value Plan which provides a 25% discount upon enrollment.

Here are some insurance considerations. **Please initial each blank below.**

_____ Our office is happy to assist you by filing your insurance claims for you, as a courtesy.
Please provide us with complete and accurate information about your dental insurance.
ANY INSURANCE BALANCE LEFT UNPAID AFTER 60 DAYS BECOMES YOUR RESPONSIBILITY.

_____ **Please be prepared to pay for services at the time of your visit.** We ask that you pay your estimated portion in full at the time of service. It is your responsibility to pay the deductible, estimated portion and any other balances not paid for by your insurance.

_____ **We are happy to provide you with an ESTIMATE of the fee for services you require.** Due to extensive and sweeping changes in the health care insurance industry, we are no longer able to obtain accurate information from your insurance company on your benefits. We cannot be responsible for determining your actual dental eligibility for benefits, pre-existing clauses, exclusion clauses, disallowed services, waiting periods, etc.

_____ YOU SHOULD CAREFULLY REVIEW YOUR DENTAL INSURANCE POLICY. If you have any questions concerning your dental insurance requirements and coverage please contact your insurance carrier or employer.

Any account balances that are not paid within a 90-day period can result in us enlisting a collection assistance company. If this does happen, a $25 collection fee will be added to your balance, which will become your responsibility. If these collection efforts are not successful, your account may be turned over to a collection agency at which time you will have to settle your account with them.

In order to provide the best care possible for all our patients**, we require a 48 hours' notice to cancel** an appointment. Failure to comply will result in a **$50 failed or missed appointment fee** for the missed appointment time.

Please sign and date that you have read and understand our financial policy.

Patient Name: _____

Signature: _____ Date: _____
(*patient, legal guardian, or authorized agent of patient*)

Fort Union Family Dental

Consent to Proceed

I authorized **Dr. Todd Larsen** 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 my 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 bronchoscope 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 or non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all reasonable medical and dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental 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.

Patient Name:_____
(print name)

Signature: _____ Date: _____
(patient, legal guardian, or authorized agent of patient)

Witness: _____ Date: _____

Fort Union Family Dental

Agreement to Receive Electronic Communication - Email and Texting Permission

Patient Name: _____ Date of Birth: _____

I agree that ***Fort Union Family Dental in Midvale, Utah*** may communicate with me electronically at the email address noted below, or text at the cell phone noted below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address or cell phone number.

I can withdraw my consent to electronic communications by calling us at (801) 562-2147.

Email Address (please print clearly):

_____ @ _____

Texting Cell Number (please print clearly):

_____

Patient Signature: _____
(patient, legal guardian, or authorized agent of patient)

Date: _____

Fort Union Family Dental

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Print Patient Name: ____

Patient Signature: ____
(patient, legal guardian, or authorized agent of patient)

Date: ____

- -

I, the above named patient, do authorize with my signature above, to speak to and/or share information regarding my Dental Health/Records with the following people:

Name: ____ Relationship: _____________

Name: ____ Relationship: _____________

Name: ____ Relationship: _____________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge that we could not obtain this as:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) ____