New Patient Form

Date:

Patient #

Patient Information

Last Name ____________ First Name ____________ Middle Name ____________

Male Female SS # ____________ Date Of Birth ____________ Nickname ____________

Relationship Status Single Married Minor Separated Divorced Widowed Partnered for ______ years

Street Address ____________ Apt # ______ City ____________ State ______ Zip Code ____________

Home # ____________ Cell # ____________ Email ____________

Employer/School ____________ Employer/School Phone ____________

Employer/School Address ____________ City ____________ State ______ Zip Code ____________

Spouse or Parents Name ____________ Employer ____________ Work # ____________

Who may we thank for referring you to our office? ____________

Person to contact in case of emergency ____________ Phone ____________

Responsible Party

Last Name ____________ First Name ____________ Middle Name ____________

Relation to Patient ____________ Date Of Birth ____________ Email ____________

Street Address ____________ Apt # ______ City ____________ State ______ Zip Code ____________

Home # ____________ Cell # ____________ Driver's License # ____________

Bank ____________ Employer ____________ Work # ____________

Currently a patient in our office? Yes No

Insurance Information

Name of Insured ____________ Relation to Patient ____________

Date Of Birth ____________ SS # ____________ Date Employed ____________

Employer ____________ Work # ____________

Employers Address ____________ City ____________ State ______ Zip Code ____________

Insurance Company ____________ Group # ____________ Union or Local # ____________

Insurance Company Address ____________ City ____________ State ______ Zip Code ____________

How much is your deductible? ____________ How much have you used? ____________ Max. Annual Benefit ____________

Secondary Insurance Information

Name of Insured ____________ Relation to Patient ____________

Date Of Birth ____________ SS # ____________ Date Employed ____________

Employer ____________ Work # ____________

Employers Address ____________ City ____________ State ______ Zip Code ____________

Insurance Company ____________ Group # ____________ Union or Local # ____________

Insurance Company Address ____________ City ____________ State ______ Zip Code ____________

How much is your deductible? ____________ How much have you used? ____________ Max. Annual Benefit ____________

Medical History Form

Date:

Patient #

Dental History

Reason for today's visit ______________________ Date of last dental care ______________

Former Dentist ______________________ Date of last dental X-rays ______________

Street Address ______________ Apt # ______ City ______________ State ______ Zip Code __________

Have you had any of the following problems? (check all that apply)

Bad breath	Grinding teeth	Sensitivity to heat
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaws	Periodontal treatment	Sensitivity when biting
Food collection between the teeth	Sensitivity to cold	Sores or growths in your mouth

How often do you floss? ______________ How often do you brush ______________

Medical History

Physician's Name ______________________ Date of last visit ______________

1. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine). Yes No
2. Have you ever had any serious illnesses or operations? Yes No
   If yes, please explain ______________________
3. Have you ever had a blood transfusion? Yes No If yes, please give approximate date ______________
4. (Women) Are you pregnant? Yes No Are you nursing? Yes No Are you taking birth control pills? Yes No
5. Have you ever had any of the following? (check all that apply)

Anemia	Congenital Heart Lesions	Hepatitis	Scarlet Fever
Arthritis, Rheumatism	Cortisone Treatments	Hernia Repair	Shortness of Breath
Artificial Heart Valves	Cough, Persistent	High Blood Pressure	Skin Rash
Artificial Joints, Pins, etc.	Cough up Blood	HIV/AIDS	Stroke
Asthma	Diabetes	Jaw Pain	Swelling of Feet or Ankles
Back Problems	Epilepsy	Kidney Disease	Thyroid Problems
Bleeding Abnormally	Fainting	Liver Disease	Tobacco Habit
Blood Disease	Glaucoma	Mitral Valve Prolapse	Tonsillitis
Cancer	Headaches	Pacemaker	Tuberculosis
Chemical Dependency	Heart Murmur	Radiation Treatment	Ulcer
Chemotherapy	Heart Problems	Respiratory Disease	Venereal Disease
Circulatory Problems	Hemophilia	Rheumatic Fever	

List any medications you are currently taking and the correlating diagnosis: ______________________

Allergies: ______________________

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature ______________________ Date ______________

Print Name ______________________ Relationship to Patient ______________

Payment is due in full at time of treatment unless prior arrangements have been approved.

39th street DENTAL

Consent And Condition Of Services

As either the patient or the legally authorized representative of the patient, on behalf of the patient receiving care in this facility, I make the following consents, understanding, and agreements on my own behalf and on behalf of the patient, in partial consideration of dental care services to be provided to the patient in the facility:

Consent for services: I herby give consent to the facility, its contractors, doctors, and employees to provide dental care services to the patient and to administer the doctor's orders for the benefit of the patient for the visit and any subsequent visits. I understand this consent may be revoked in writing at any time.

Release of information: The facility is required by law to make and keep records of the patient's dental treatment. The facility safeguards those records and it uses and discloses and the information they contain only in the accordance with the state and federal privacy laws. Such uses and disclosures are described in detail in the facility's Notice of Privacy Practices, which may be amended from time to time. I understand that either the patient or I may ask to see a copy of the current notice at any time.

Assignment of Benefits: Any and all benefits from insurance companies and other third party payers that re payable to the patient or on behalf of the patient for dental care services and related payments for services rendered or provided to the patient are herby transferred and assigned to the facility for the exclusive purpose of paying for charges associated with the dental care services provided to the patients in the facility. I understand and intend that all insurance companies and the other third party payers will pay benefits directly to the facility in payment of the facility's charges and the charges of any other dental care providers for whom the facility is authorized to bill in connection with dental care services provided to the patient.

Financial Responsibility: Patient and the undersigned, if other then the patient, each jointly and severally agree to pay for all the dental care services rendered to the patient in the facility including but no limited to any amount not paid by the insurance company or other third party payer (excluding contract discounts.) Patient and the undersigned, if other then the patient, remain responsible for all co-payments, deductibles, co-insurance and/or non-covered services regardless of amount paid by insurance or third party payer. I understand and agree that any amounts not paid within 30 days of the date of the facility's bill or statement for payments shall accrue interest at the rate of 1 ½% per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collections. Patient and the undersigned, if other then the patient, each jointly and severally agree to pay costs up to 40% and reasonable attorney's fees in connection with the collection's process. A service charge may be collected in connection with any check or other instrument tendered by the patient or the undersigned but returned unpaid to the facility.

The undersigned signs this document wither as the patient or as the agent or representative of the patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document. This document will remain in effect unless revoked in writing.

Patient Name ______________________________ Date of Birth ____________________

Signature: ______________________________ Date: ____________________

Witness to Signature ______________________________ Relationship to Patient ____________________

39th Street Dental, 1377 East 3900 South Ste 101, Salt Lake City, Utah 84124, (801)272-1199

39th street DENTAL

OFFICE POLICY REGARDING FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

39th STREET DENTAL
DR. BRAITHWAITE & DR. PINEGAR

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance, and your understanding of out payment insurance submittal policy.

As a service and convenience to you, we will file insurance claims for you. Your insurance coverage is a contract between you, your employer and the insurance company. We are not party in this contract. Our relationship is with you and not your insurance company. All charges are your responsibility.

It is your responsibility to confirm the doctor you are seeing is on your insurance provider list, and what charges will not be covered.

Our office will bill your insurance as a courtesy to you. We will bill your second insurance if you contact us after your primary insurance has paid.

We require all co-payments to be made at the time of service. We have no control over what your insurance companies will or will not pay. We have found that some insurance companies do not cover ALL dental services. Upon receipt of your payment from your insurance company, we will bill you for the outstanding balance.

IF YOU DO NOT HAVE INSURANCE:
We require you to sign a financial agreement for the total amount of your billing.

If you have any questions about our financial policy, please do not hesitate to ask. We are here to help.

I have read, understand and agree to the policy above.

Signature ____ Date ______________________