GENERAL INFORMATION

This information is requested for financial and credit purposes:

SUBSCRIBERS INFORMATION: ______________________________

NAME: ______________________ DATE OF BIRTH: ______________________
HOME ADDRESS: ______________________________
HOME PHONE: ______________________ WORK PHONE: ______________________
EMPLOYER: ______________________ S.S.N.: ______________________
WORK ADDRESS: ______________________________
NAME OF INSURANCE CARRIER: ______________________ POLICY #: ______________________
ADDRESS: ______________________ PHONE NUMBER: ______________________

SPOUSE INFORMATION:
NAME: ______________________ DATE OF BIRTH: ______________________
EMPLOYER: ______________________ WORK NUMBER: ______________________
WORK ADDRESS: ______________________ S.S.N.: ______________________
NAME OF INSURANCE CARRIER: ______________________ POLICY #: ______________________
ADDRESS: ______________________ PHONE NUMBER: ______________________

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

AUTHORIZATION

I authorize Hillfield Pediatric & Family Dentistry to furnish my insurance company with all information to process my dental claim(s). I authorize the above named insurance company to pay all benefits due me directly to Hillfield Pediatric & Family Dentistry. I understand that I am financially responsible for charges not covered by this assignment.

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any necessary dental treatment can be rendered. A finance charge of 1.5% per month (18% per annum) will be charged on accounts 60 days past due. Should collection become necessary, the undersigned specifically agrees to pay an additional 40% collection fee and all legal fees of collection with or without suit, including attorney fees and court costs. This additional amount is in recognition of the costs associated with said collection action processing.

Signature: ______________________ Date: ______________

MEDIATION/ARBITRATION AGREEMENT: Any claim or controversy between the patient and/or a legally authorized representative of the patient and dentist concerning the care and treatment or the quality of dental services rendered by the dentist to the patient shall be resolved by mediation or arbitration according to the rules of WESTERN MEDIATION, should any dispute arise regarding the quality of dental services rendered. A claim or controversy shall first be submitted to non-binding mediation. If the claim or controversy is not resolved to the satisfaction of both parties through mediation process, it will be submitted to binding arbitration. Judgement(s) on the decision achieved through mediation or rendered by the arbitrator(s) can be entered in any court having jurisdiction thereof. Costs for mediation and/or arbitration services shall be shared equally by the parties involved. The forgoing mediation/arbitration agreement does not pertain to actions taken for the collection of debts owed as a result of dental services rendered.
A FINANCE CHARGE OF 1.5% PER MONTH (18% PER ANNUM) WILL BE CHARGED ON ACCOUNTS 60 DAYS PAST DUE. THE DEBTOR AGREES TO PAY ALL COLLECTION COSTS, REASONABLE ATTORNEY FEES AND INTEREST AND AGREES THAT THE DEBT IS DUE, PAYABLE IN DAVIS COUNTY, SATE OF UTAH.

Signature: ______________________ Date: ______________ (Patient, legal guardian or authorized agent of patient)

Witness: ______________________ Date: ______________

MEDICAL HISTORY:

Patient Name: ______________________ Date of Birth: ______________________
Physician's Name: ______________________ Phone: ______________________

Please answer the following questions as completely as possible (circle "YES" or "NO")

1.	Do you consider yourself to be in good health?	YES	NO
2.	Are you now or have you been under a physician's care within the past year?	YES	NO
	If yes, specify condition being treated ______________________	YES	NO
3.	Do you take any medications, including birth control pills?	YES	NO
	Please specify name and purpose of medications: ______________________		
4.	Do you have or have you ever had any heart or blood problems?	YES	NO
5.	Have you ever been told that you have a heart murmur?	YES	NO
6.	Do you require antibiotic premedication for a heart condition, artificial valve or artificial joint?	YES	NO
7.	Do you have or have you ever had high blood pressure?	YES	NO
8.	Do you bleed or bruise easily?	YES	NO
9.	Have you ever been diagnosed as being HIV positive or having AIDS?	YES	NO
10.	Have you ever had hepatitis or liver disease?	YES	NO
11.	Have you ever had: rheumatic fever ______ : asthma ______ : any blood disorder ______: diabetes ______ : rheumatism ______: arthritis ______ : tuberculosis ______ : venereal disease ______ : heart attack ______ : Kidney disease ______ : immune system disorders ______ : other disease ______ ? If so specify: ______________________		
12.	Have you ever had an unusual reaction or are you allergic to any of the following drugs:	YES	NO
	Penicillin ______ : Aspirin ______ : Acetominophen ______ : Ibuprofen ______ : Codeine ______ :	YES	NO
	Barbiturates ______ : Sulfa Drugs ______ : Other ______________________	YES	NO
13.	Are you subject to fainting?	YES	NO
14.	Have you ever had any severe reaction to dental treatment or local anesthetics?	YES	NO
15.	Are you allergic to any local anesthetic?	YES	NO
16.	Do you have any other allergies? If yes, please describe: ______________________	YES	NO
17.	Have you ever had a nervous breakdown or undergone psychiatric treatment?	YES	NO
18.	Have you ever received counseling for excessive use of alcohol and/or prescription drugs?	YES	NO
19.	Women: Are you pregnant?	YES	NO
20.	Are you now in pain?	YES	NO
21.	How long ago did you last see a dentist? ______________________		
22.	Who was your previous dentist? ______________________		
23.	Do you think that your teeth are affecting your general health in any way?	YES	NO
24.	Do you have or have you ever had bleeding or sensitive gums?	YES	NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE

Signature ______________________ Date ____________ D.D.S. ____________
(Patient, legal guardian or authorized agent of patient)

Signature ______________________ Date ____________ D.D.S. ____________

Signature ______________________ Date ____________ D.D.S. ____________

Signature ______________________ Date ____________ D.D.S. ____________