

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, STATE 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 _____ : Acetaminophen _____ : Ibuprofen _____ : Codeine _____ :
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. _____