GENERAL INFORMATION

This information is requested for financial and credit purposes:

INSURANCE INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

HOME ADDRESS: _____

HOME PHONE: _____ **WORK PHONE:** _____

EMPLOYER: _____ **S.S.N.:** _____

WORK ADDRESS: _____

NAME OF INSURANCE: _____ **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 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.

Guardian/Parent Signature (Children under the age of 18): _____ Date: _____

Signature (18 or older): _____ 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 the 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 foregoing 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. (Patient, legal guardian or authorized agent of patient)

Guardian/Parent Signature (Children under the age of 18): _____ Date: _____

Signature (18 or older): _____ Date: _____

MEDICAL HISTORY (Adult)

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone: _____

Please answer the following questions as completely as possible.

1. Do you consider yourself to be in good health? ☐ YES ☐ NO
2. Do you require antibiotic premedication for a heart condition, artificial valve or artificial joint? ☐ YES ☐ NO
3. Are you now or have you been under a physician's care within the past year? ☐ YES ☐ NO
   If yes, specify condition being treated _____
4. Do you take any medications, including birth control pills? ☐ YES ☐ NO
   Please specify name and purpose of medications: _____
   _____
5. Are you subject to fainting? ☐ YES ☐ NO
6. Have you ever had any severe reaction to dental treatment or local anesthetics? ☐ YES ☐ NO
7. Are you allergic to any local anesthetics? ☐ YES ☐ NO
8. Do you have any other allergies? If yes, please describe: ☐ YES ☐ NO
   _____
9. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? ☐ YES ☐ NO
10. Women: Are you pregnant? ☐ YES ☐ NO
11. Are you now in pain? ☐ YES ☐ NO
12. How long ago did you last see a dentist? _____
13. Who was your previous dentist? _____
14. Do you think that your teeth are affecting your general health in any way? ☐ YES ☐ NO
15. Do you have or have you ever had bleeding or sensitive gums? ☐ YES ☐ NO
16. Do you smoke, Vape and/or drink alcohol? ☐ YES ☐ NO
    Cigarettes per day? _____ How often do they Vape per day? _____ alcohol consumption per day? _____
17. Have you experienced any of the following? *(Please check all that apply)*

☐ heart problems	☐ HIV positive	☐ blood disorder	☐ heart attack	☐ immune system disorders
☐ blood problems	☐ AIDS	☐ diabetes	☐ kidney disease	☐ nervous breakdown
☐ heart murmur	☐ hepatitis	☐ rheumatism	☐ asthma	☐ hsychiatric treatment
☐ high blood pressure	☐ liver disease	☐ arthritis	☐ bleeding	☐ bleeding/sensitive gums
☐ bleed/bruise easily	☐ rheumatic fever	☐ tuberculosis	☐ venereal disease	☐ other disease

   If so specify: _____
   _____
   _____
18. Have you ever had an unusual reaction or are you allergic to any of the following? *(Please check all that apply)*

☐ Penicillin	☐ Aspirin	☐ Acetaminophen	☐ Ibuprofen	☐ Codeine
☐ Barbiturates	☐ Sulfa Drugs	☐ Other _____		

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. _____