SALT LAKE DENTAL

Welcome to Salt Lake Dental

Date_____

Patient Information

Name_____Social Security_____

DOB_____Age_____E-mail_____

Gender: Male ___ Female___ Married___ Single___ Child___ Widowed___ Separated___ Divorced___ Partnered___

Address_____City_____State_____Zip_____

Home Phone:(____)_____ Cell Phone(____)_____Work Phone(____)_____

Employer/School_____ Employer_____

Work Address_____ Employer/School Phone(____)_____

Whom may we thank for referring you?_____

Emergency contact

Person to contact in case of Emergency Name_____Phone _(____)_____

Insurance Information Primary

Person responsible for account_____

Relation to patient_____DOB_____ID#/Soc. Sec.#_____

Address (if different from patient's)_____ Phone(____)_____

City_____State_____ Zip_____

Employer_____ Occupation_____

Work Address_____Work Phone(____)_____

Insurance Company_____

Insurance Phone(____)_____Group #_____ Subscriber #_____

Secondary

Person responsible for account_____

Relation to patient_____DOB_____ID#/Soc. Sec.#_____

Address (if different from patient's)_____ Phone(____)_____

City_____State_____ Zip_____

Employed By_____ Occupation_____

Business Address_____Work Phone(____)_____

Insurance Company_____

Insurance Phone(____)_____Group #_____ Subscriber #_____

I certify that I, and/or my dependent(s), have insurance with _____ _____and assign directly to Dr. B. Tysen Carter, DMD all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature and any of my other information on all insurance submissions. I understand that payment is due in full at the time of treatment.

_____ _____ _____ _____

Print Name *Signature* *Relationship to Patient* *Date*

PATIENT MEDICAL HISTORY

PATIENT NAME _____ *Birth Date* _____

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	O Yes O No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisophonates?	O Yes O No	_____
Are you on a special diet?	O Yes O No	
Do you use tobacco?	O Yes O No	
Do you use controlled substances?	O Yes O No	

Women: Are you:

Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following? (please circle)

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Sulfa Drugs

O Other: If yes, please explain:

Do you have, or have you had, any of the following? (please circle)

O AIDS/HIV Positive	O Cold Sores/Fever Blisters	O Glaucoma	O Leukemia	O Sickle Cell Disease
O Alzheimer's Disease	O Congenital Heart Disorder	O Hay Fever	O Liver Disease	O Sinus Trouble
O Anaphylaxis	O Convulsions	O Heart Attack/Failure	O Low Blood Pressure	O Spina Bifida
O Anemia	O Cortisone Medicine	O Heart Murmur	O Lung Disease	O Stomach/Intestinal Disease
O Angina	O Diabetes	O Heart Pacemaker	O Mitral Valve Prolapse	O Stroke
O Arthritis/Gout	O Drug Addiction	O Heart Trouble/Disease	O Osteoporosis	O Swelling of Limbs
O Artificial Heart Valve	O Easily Winded	O Hemophilia	O Pain in Jaw Joints	O Thyroid Disease
O Artificial Joint	O Emphysema	O Hepatitis A	O Parathyroid Disease	O Tonsilitis
O Asthma	O Epilepsy or Seizures	O Hepatitis B or C	O Psychiatric Care	O Tuberculosis
O Blood Disease	O Excessive Bleeding	O Herpes	O Radiation Treatments	O Tumors or Growths
O Blood Transfusion	O Excessive Thirst	O High Blood Pressure	O Recent Weight Loss	O Ulcers
O Breathing Problem	O Fainting Spells/Dizziness	O High Cholesterol	O Renal Dialysis	O Venereal Disease
O Bruise Easily	O Frequent Cough	O Hives or Rash	O Rheumatic Fever	O Yellow Jaundice
O Cancer	O Frequent Diarrhea	O Hypoglycemia	O Rheumatism	
O Chemotherapy	O Frequent Headaches	O Irregular Heartbeat	O Scarlet Fever	
O Chest Pains	O Genital Herpes	O Kidney Problems	O Shingles	

Have you ever had any serious illness not listed above? O Yes O No _____

Comments:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) *Date*

Consent for Services / Financial Policy

We are committed to providing you with the best possible care. We understand that every persons financial situation is different and your clear understanding of our financial policy is important to our professional relationship.

Broken appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **48** hours notice to avoid a $60 an hour charge for the doctor's time and $60 cancellation fee for a cleaning (emergencies are an exception).

Collection Fee, Attorney Fees, & Interest:
I agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.

TCPA Prior Express Consent Clause:
We want to stay in touch with you regarding your account. You agree, in order for us to service your account or collect any amounts you may owe, we may contact you by telephone at any telephone number, including wireless telephone numbers that have or may attain, which could result in charges to you.

Arbitration Clause:
I agree that if there is a dispute as to the care or treatment for the services provided that either party may elect to have the claim resolved in arbitration, and that I will pay all costs of arbitration. This agreement to arbitrate revokes any previous arbitration and/or mediation agreement previously signed by myself or my agent. The forgoing arbitration agreement specifically excludes actions taken for the collection of debts owed as result of services provided.

Patient Signature _____ **Date** _____

Witness Signature _____ **Date** _____

CONSENT TO PROCEED

*I authorize **Salt Lake Dental, LLC** and or such associates or assistants as he or she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health or 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.

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. After lengthy appointments, jaw muscles may also be sore or tender. 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 (inhale 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 broncho scope or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which 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: _____

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

Witness:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

Salt Lake Dental LLC

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____Date of Birth_____

Signature _____

Date _____

SALT LAKE DENTAL

Smile Questionnaire

Here at Salt Lake Dental we want to make sure we are taking care of all your wants and needs.

Please fill out the form below so we can provide you with the best experience possible!

PATIENT NAME: _____

1. Are you pleased with the appearance of your teeth? YES NO
   a. If no, what would you like to change about your smile?

   _____

   _____
2. Would you like your teeth to be whiter? YES NO
3. Would you like your teeth to be straighter? YES NO
4. Are you eager to keep your natural teeth? YES NO
   a. If so, do you plan to keep your natural teeth for the rest of your life if possible?

      YES NO
5. Please circle all that apply to you:

   Loose teeth Sore Gums Gagging Missing Teeth

   Bad Breath Earaches Sensitive teeth
6. How high on your list of priorities is your dental care?

   HIGH MEDIUM LOW
7. Is your main reason for coming to the dentist...

   HYGIENE COSMETIC TOOTHACHE
8. How comfortable are you coming to the dentist? Scale of 1-10 (10 being very comfortable): _____
9. Are you interested in facial aesthetics such as Botox or Derma fillers (wrinkle reduction or lip injections)? YES NO

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