PROVO FAMILY
DENTISTRY

Today's Date _____

Patient Name: _____ Preferred Name: _____
Last First MI

Date of Birth: _____ Gender at Birth: ☐M ☐F Please indicate if you are: ☐Married ☐Single ☐Minor

Phone (h) _____ Phone (w) _____ Phone (c) _____

Address: _____
Street Apt # City State Zip Code

Employer: _____ Social Security #: _____

E-mail: _____

Whom may we thank for referring you to our practice? _____

RESPONSIBLE PARTY INFORMATION

Patient Name: _____ Relationship: _____
Last First MI

Phone (c) _____ SSN: _____ Date of Birth: _____

Address: _____
Street Apt # City State Zip Code

EMERGENCY CONTACT INFORMATION (NOT LIVING WITH YOU)

Name: _____ Phone: _____ Relationship: _____

Address: _____
Street Apt # City State Zip Code

PRIMARY INSURANCE INFORMATION

It is your responsibility to know your insurance benefits. We cannot possibly know all the provisions and requirements for every plan.

Name of Policy Holder: _____ ID #: _____

Policy Holder Address: _____
Street Apt # City State Zip Code

Policy Holder Date of Birth: _____ SSN: _____ Relationship: _____

Insurance Company: _____ Ins. Phone: _____ Employer: _____

SECONDARY INSURANCE COMPANY

Name of Policy Holder: _____ ID #: _____

Policy Holder Address: _____
Street Apt # City State Zip Code

Policy Holder Date of Birth: _____ SSN: _____ Relationship: _____

Insurance Company: _____ Ins. Phone: _____ Employer: _____

CONSENT TO PROCEED

- I authorize Dr. Steven Flick, Dr. Gary Wilson, Dr. Tyra Neal, and/or such associates or assistants as he/she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement for 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 or altered sensation.
- I understand that occasionally needles break and may require surgical retrieval.
- Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.
- I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, that teeth may remain sensitive or even possibly have pain both during and/or after completion of treatment.
- Dental materials and medications may trigger allergic or sensitivity reactions.
- After lengthy appointments, jaw muscles may be sore or tender.
- Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder.
- Gums and surrounding tissues may 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 or materials including, but not limited to crowns, small dental instruments, drill components, burs, etc. may be aspirated (inhaled 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 bronchoscopy or other procedures to ensure safe removal.
- I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen.
- I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.
- I do voluntarily assume any and all possible risks, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or 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 (print) Date

_____ _____

Signature of Responsible Party (patient or parent/legal guardian if patient is a minor) Date

_____ _____

Witness to Signature Date

Medical/Dental Health History Form

Last Name: _____ First Name: _____ Middle Initial: ____ ☐M ☐F
Gender at Birth

Address: _____ Date of Birth: _____
Street City State Zip Code

Phone (c): _____ Email: _____

How do you prefer that we contact you? _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Medical History

Date of your last physical exam? _____

Physician's Name: _____ City/State: _____ Phone: _____

	Yes	No
Do you consider yourself to be in good health?	☐	☐
Has there been any change in your general health in the past year?	☐	☐
Have you ever taken any diet drugs such as Pondimin or Redux?	☐	☐
Have you had a serious illness, operation, or been hospitalized in the past five years?	☐	☐
If yes, what was the illness or concern? _____		
Were you ever treated for osteoporosis?	☐	☐
Were you ever treated with/are you scheduled to be treated with intravenous bisphosphonates?	☐	☐
Have you ever had a joint replacement?	☐	☐

On a scale of 1-10 (10 being the best possible), how would you rate the quality of your sleep (indicate by circling)? 1 2 3 4 5 6 7 8 9 10

Do you have or have you ever had tuberculosis? Yes ☐ No ☐ Have you ever had a positive TB skin test? Yes ☐ No ☐

WOMEN ONLY:	No	Yes
Are you pregnant or lactating?	☐	☐ → If pregnant, how many weeks? _____
Are you taking birth control pills or hormone therapy?	☐	☐

Please indicate by checking if you have or have had any of the following:

☐ thyroid problems	☐ sinus problems	☐ arthritis	☐ gastrointestinal disease
☐ kidney problems/dialysis	☐ seasonal allergies	☐ chronic pain	☐ GERD/reflux
☐ hepatitis/liver disease	☐ asthma	☐ sleep apnea or other sleep disorder	☐ ulcers
☐ infective endocarditis	☐ wheezing/shortness of breath	☐ frequent headaches	☐ special diet
☐ congenital heart defects	☐ chronic bronchitis	☐ epilepsy or seizures	☐ eating disorder
☐ cardiovascular disease	☐ emphysema	☐ autoimmune disease	☐ cancer/chemo/radiation
☐ congestive heart failure	☐ COPD	☐ cold sores or fever blisters	☐ physical limitation(s)
☐ CVA (stroke)	☐ persistent cough	☐ AIDS/HIV	☐ fainting
☐ high or low blood pressure	☐ mouth breathing	☐ hemophilia	☐ significant/rapid weight change
☐ pacemaker or defibrillator (ICD)	☐ snoring	☐ anemia	☐ excessive hunger/urination/thirst
☐ angina/chest pain on exertion	☐ dizziness	☐ glaucoma	☐ prediabetes
☐ damaged/artificial heart valves	☐ persistent swollen glands in neck	☐ blood clotting problems/abnormal bleeding	☐ diabetes → if yes, ☐ type I or ☐ type II
☐ MI (heart attack) → if yes, date: _____	☐ recurrent infections → specify: _____	☐ depression/anxiety/mental disorder → specify: _____	☐ frequent daytime tiredness

Has a physician ever recommended that you take antibiotics prior to dental care or dental work? No ☐ Yes ☐

Has a physician ever recommended that you wear a CPAP or a BiPAP? No ☐ Yes ☐

History of or current use of alcohol/controlled substance/recreational drug? No ☐ Yes ☐

Do you have any disease, allergy, condition, problem, or concern not listed on this form? No ☐ Yes ☐ →specify:

Are you allergic to (or have you ever had an allergic reaction to) any of the following. If yes, please specify the nature of the reaction:

			specify:				specify:
local anesthetics	No ☐	Yes ☐		penicillin or other antibiotics	No ☐	Yes ☐	
aspirin or NSAID	No ☐	Yes ☐		barbiturates, sedatives, sleeping pills	No ☐	Yes ☐	
sulfa drugs	No ☐	Yes ☐		codeine or other narcotics	No ☐	Yes ☐	
metals	No ☐	Yes ☐		latex	No ☐	Yes ☐	
iodine	No ☐	Yes ☐		hay fever/seasonal allergies	No ☐	Yes ☐	
other	No ☐	Yes ☐					

Please list any prescription or over-the-counter medicines that you are currently taking, including vitamins, natural medicines, homeopathic and/or herbal supplements or remedies (if you need more space, please ask the desk for an additional piece of paper):

Prescription	over-the-counter

Dental History

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are you currently experiencing dental pain/discomfort?	☐	☐
Are your teeth sensitive to hot/cold/sweets/pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth often dry?	☐	☐
Have you ever had periodontal (gum) treatment or a "deep cleaning"?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Have you had orthodontic treatment (braces or aligners)?	☐	☐
Have you had a serious injury to your head or mouth?	☐	☐
Do you ever experience sores or ulcers in your mouth?	☐	☐
Do you ever have cracking of the corners of your mouth?	☐	☐

	Yes	No
Have you always been seen regularly by the dentist?	☐	☐
Do you brux (grind) or clench your teeth?	☐	☐
Have you ever had any problems associated with previous dental treatment?	☐	☐
Have you ever had problems with teeth/fillings breaking?	☐	☐
Do you have clicking, popping, or other discomfort in your jaw?	☐	☐
Do you experience earaches or neck pains?	☐	☐
Do you have difficulty opening your mouth widely?	☐	☐
Have you ever had burning of your tongue?	☐	☐
Do you have a strong gag reflex?	☐	☐

Date of your last dental exam:

What is the reason for your visit today?

How do you feel about your smile?

What can we can do/not do to make you feel more comfortable during your dental visits?

1. Do you use or have you ever used tobacco products? No ☐ → Yes ☐ →

if no, please skip the rest of this box

if yes, please indicate each of the following:

a. ☐past user ☐currently using

b. which form(/s) of tobacco product were/are used?
☐smoke ☐snuff ☐chew

c. how much AND how frequently do/did you use tobacco? _____pack(s) per _____

d. if currently using, are you interested in learning how to quit? No ☐ Yes ☐

I understand the importance of furnishing my health care providers with a truthful and complete health history and that my dentist and his/her team will carefully review the information provided herein and use it when determining appropriate personalized treatment. I understand that incorrect information could pose a serious threat to my own health. I release Provo Family Dentistry and the health care providers and team members employed thereby from all liability associated with any actions that they take or do not take based on information either misreported on, misrepresented on, or omitted from this form. I acknowledge that any questions I have or had while filling out this form have been answered to my satisfaction. I consent to the release of medical/dental information to my dentist, physician, or other healthcare professional if requested. If ever there are any changes to my health history, status or to my medications, I will inform the health care provider(s) at my next appointment. I hereby grant permission to be treated at Provo Family Dentistry.

_____ _____ _____ _____

Signature of Patient/Legal Guardian Date Signature of Dentist/Health Care Provider Date

HIPAA – Health Insurance Portability Accountability Act:

We will use your protected health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize coordination between hygienist, dental assistant, dentist, and office staff. We may share your information to collect payment for treatment you receive in our office. Your health information may be used during performance evaluations of our staff. We may be required to disclose to federal officials or military authorities health information necessary to complete an investigation related to public health or national security. We may notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. Because we believe regular care is very important to your oral and general health, it will be necessary to use your information to contact you regarding your treatment, including scheduling, follow-up care and reminder calls.

_____ _____

Signature of Patient or Legal Guardian (parent/legal guardian if patient is a minor) Date

FINANCIAL AGREEMENT

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of the estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all our patients. Therefore, we offer the following payment options:

1. Cash, check, or credit card payment (we do not accept American Express)
2. Flexible payment plans of up to 12 months upon approval with Care Credit. Approval must be received prior to treatment date.
3. 3 month in-house automatic payment plan

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately, with the information provided to us by your insurance company, we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims. I realize I'm financially responsible for all the charges incurred, regardless of the insurance coverage. I am aware that past due accounts will be subject to a charge of 1.5% per monthly interest. I am responsible for all collection costs incurred by the dental office. Up to 40% may be added for collection costs and a returned check fee of $20.00. I have read, understand, and agree to the above policies.

Regardless of any insurance I may have, I am ultimately responsible for the payment of any professional services rendered. I authorize my insurance company to pay Provo Family Dentistry, Dr. Steven Flick, Dr. Gary Wilson, Dr. Tyra Neal, and/or such associates or assistants as he/she may designate, on my behalf. This will remain in effect until revoked by me in writing.

_____ _____

Signature of Responsible Party (patient or parent/legal guardian if patient is a minor) Date

Patient's Name (please print) _____

DENTAL APPOINTMENT AGREEMENT

Rescheduling Appointments

When you reserve an appointment with our team, please keep in mind that we have reserved time for you in one of our chairs for our team to be available to provide you with dental service. We value your time and do our best to provide you with quality dental services in an efficient and effective manner. When you reserve an appointment with our team you will be entered into our systems to receive a reminder/confirmation of your reserved appointment via texts, emails, and phone calls. You will receive these notifications at 1 week and 24 hours prior to your reserved appointment.

If you find that you have reserved an appointment with our office and need to reschedule it, please call our office at least 24 hours in advance to request a change to your reserved time with our team.

Missed Appointments or Late for Appointments

If you cancel a reserved appointment with less than 24 hours' notice or you are more than 10 minutes late for an appointment, it will be noted in our records and you will be subject to a minimum Missed Appointment Fee of $60.00 per hour of reserved chair time. If you are late for your appointment, we may have to reschedule you for another time if there is not enough remaining time to complete your procedure.

Example assessments of late fees:

- 1 family member for 1 hour = $60.00
- 1 family member for 2 hours of chair time missed = $120.00
- 2 family members for 1 hour each = $120.00
- 2 family members for 2 hours each = $240.00, etc.

If you do miss a reserved appointment or are more than 10 minutes late for a reserved appointment, we may request to have your credit card information prior to reserving your next appointment.

We reserve the right to discontinue providing all dental services to patients that have 3 or more missed appointments.

By signing this document, I understand the above noted appointment agreement and that it applies to me and other family members that are associated with my account at Provo Family Dentistry. I also agree to follow the terms of the above noted agreement/policy.

_____ _____

Patient Name (please print) Date

_____ _____

Patient or Guardian Signature Date