PATIENT INFORMATION SHEET

Date:_____ **Referred By:**_____

Patient's Name:_____ **SSN:**_____ **Date of Birth:** _____

Address: _____ **City/Zip:**_____

Phone #:_____ **Sex: M / F Marital Status: M / S / W / D No. of Dependents:**_____

Email Address:_____ **Cell Phone #:** _____

Emergency Contact Person:_____ **Relationship:**_____

Address:_____ **Phone #:**_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

(If Different than Above)

Name of Responsible Person:_____ **Relationship:**_____

Residence Address:_____ **City/Zip:**_____

Hm. Phone #:_____ **SSN:**_____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW;

PRIMARY INSURANCE

(Use your Identification Card)

Insured's Name:_____ **SSN:**_____ **DOB:**_____

Patient's Relationship to Insured: Self:_____ **Spouse:**_____ **Child:**_____ **Other:**_____

Employer:_____ **Phone #:**_____ **Group ID:**_____

Insurance Company:_____ **Member ID:** _____

Claims address:_____

SECONDARY INSURANCE

(Use your Identification Card)

Insured's Name:_____ **SSN:**_____

Patient's Relationship to Insured: Self:_____ **Spouse:**_____ **Child:**_____ **Other:**_____

Employer:_____ **Phone #:**_____ **Group ID:** _____

Insurance Company:_____ **Member ID #:**_____

MEDICAL HISTORY

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

PHYSICIAN'S NAME:_____ **PHONE:**_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

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_____		
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 pre-medication for a heart condition or artificial valve?**	**YES**	**NO**
7.	**Have you ever had joint replacement surgery?**	**YES**	**NO**
8.	**Do you have or have you ever had high blood pressure?**	**YES**	**NO**
9.	**Do you bleed or bruise easily?**	**YES**	**NO**
9.	**Have you ever been diagnosed as being HIV positive or having AIDS?**	**YES**	**NO**
11.	**Have you ever had hepatitis or liver disease?**	**YES**	**NO**
12.	**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:		
13.	**Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetominophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other**		
14.	**Are you subject to fainting?**	**YES**	**NO**
15.	**Have you ever had any severe reaction to dental treatment or local anesthetics?**	**YES**	**NO**
16.	**Are you allergic to any local anesthetic?**	**YES**	**NO**
17.	**Do you have any other allergies? If Yes, please describe:**_____	**YES**	**NO**
18.	**Have you ever had a nervous breakdown or undergone psychiatric treatment?**	**YES**	**NO**
19.	**Have you ever received counseling for use of alcohol and/or prescription drugs?**	**YES**	**NO**
20.	**Women: Are you pregnant?**	**YES**	**NO**
21.	**Are you now in any dental pain?**	**YES**	**NO**
22.	**How long ago did you last see a dentist?** _____		
23.	**Who was your previous dentist?**_____		
24.	**Do you think that your teeth are affecting your general health in any way?**	**YES**	**NO**
25.	**Do you have or have you ever had bleeding or sensitive gums?**	**YES**	**NO**
26.	**Have you ever used or are you now using tobacco or alcohol?**	**YES**	**NO**
27.	**Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease The resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?**	**YES**	**NO**

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ **Date**_____

(Patient, legal guardian or authorized agent of patient)

(Rev. 8/06)

CONSENT TO PROCEED

I authorize Dr. Andrew Ericksen DDS and/or such associates or assistants as s/he 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 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. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

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. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. 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 (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, 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 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: _____

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

Witness: _____ **Date:** _____

(Rev. 7/08)

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 18% per month* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing, if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior signed agreements, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form, to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____

Signature of Patient, parent or guardian **Date**

Relationship to Patient_____

(Rev. 4/10)

***The interest rate charged may be at the discretion of your office or accountant.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: _____

DOB: _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Holladay Dental Studio 801-277-9213

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE **(THIS IS FOR MYSELF AND ALL MEMBERS OF MY FAMILY UNDER 18 YEARS OF AGE)**

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THE

NOTICE OF PRIVACY PRACTICES AND THIS CONSENT AFTER SIGNING

PLEASE ADVISE US IF YOU WOULD LIKE A COPY