Patient Information

Patient Name (last, first, MI) ______________________ Preferred Name ______________________ Date ______________

Gender: ______ Married: _____ Single: ______ Age: _______ Email Address ______________________

Social Security # ______________________ Date of birth ______________________

Phone (home) ______________ (work) ______________ ext. ______ (cell) ______________

Address ____
Street Apartment # City, State, Zip Code

Spouse or Responsible Party Information

(If you plan to bring an insurance card, you don't need fill out this section)

Name (last, first, MI)a ______________________ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # ______________________ Date of birth ______________________

Phone (home) ______________ (work) ______________ ext. ______ Best time to call ______________

Address ____
Street Apartment # City, State, Zip Code

Insurance Information

(If you plan to bring an insurance card, you don't need fill out this section)

Primary Insurance

Name of insured ______________________ Relationship to patient ☐ self ☐ spouse ☐ child ☐ other ______________

Insured's birth date ______________________ ID # ______________ Group # ______________

Secondary Insurance

Name of insured ______________________ Relationship to patient ☐ self ☐ spouse ☐ child ☐ other ______________

Insured's birth date ______________________ ID # ______________ Group # ______________

Consent for Services

As a condition of my treatment by this office, payment is expected in full at time of service. If financial arrangements are necessary they must be made in advance. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I agree that interest will accrue on all past-due amounts over 30 days at the rate of 18% per annum (1.5% per month) until paid in full.

I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. If I carry dental insurance I understand that all dental services furnished are charged directly to me and that I am personally responsible for payment of all dental services. This office will help prepare insurance claims or assist in making collections from insurance companies and will credit any such collections to my account. However, this dental office cannot render services on the assumption that my charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, see, 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters/leave messages (either voicemail or with a family member) related to this form. This agreement supersedes all prior agreements signed, 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 been given the opportunity to receive a copy of Dr. Clark B. Hicken's Notice of Privacy Practices. I have also had a chance to review the Notice of Privacy Practices in the office. I understand that Personal Health Information may be used and disclosed for treatment, payment, or healthcare operations. I understand that I have the right to review Dr. Clark B. Hicken's privacy notice at any time. I have a right to request restrictions and/or revoke consent in writing if agreed to by Dr. Clark B. Hicken. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

* It is the responsibility of the patient not the dental office to know what is covered and what is excluded from her or his own dental plan. We will do our best to inform you of what we know of your dental plan but ultimately you are responsible for any and all charges not covered.

Signature______________________ *Date:*__________ *Relationship to patient* ______________

Health Information

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private.

1. Are you being treated for any medical condition at the present time or have you been treated within the past year? If so, why? ☐ Yes ☐ No
2. When was your last dental checkup?
3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. ☐ Yes ☐ No
4. Do you have any allergies? If you answered yes, please list using the categories below: ☐ Yes ☐ No
   a. Medications (please list)
   b. latex/rubber products
   c. other e.g. hayfever, foods
   d. other (please explain)
5. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ☐ Yes ☐ No
6. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No
7. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No
8. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ Yes ☐ No
9. Do you have or have you ever had any of the following? Please check.

☐ AIDS	☐ Drug/alcohol dependency	☐ Kidney disease	☐ Radiotherapy/steroid therapy
☐ Anemia	☐ Glaucoma	☐ Leukemia	☐ Rheumatic fever
☐ Arthritis	☐ Heart attack	☐ Liver disease	☐ Seizures (epilepsy)
☐ Asthma	☐ Heart disease	☐ Lung disease	☐ Sinus problems
☐ Bleeding disorder	☐ Heart murmur	☐ Mental disorders	☐ Stomach ulcers
☐ Cancer	☐ Hepatitis (Type)______	☐ Mitral valve prolapse	☐ Stroke
☐ Chemotherapy treatment	☐ High blood pressure	☐ Nervousness/Anxiety	☐ Tuberculosis
☐ Depression	☐ HIV	☐ Pacemaker	☐ Thyroid disease
☐ Diabetes	☐ Jaundice	☐ Prosthetic heart valve	☐ Venereal disease

☐ Other (please explain)

10. Who is your primary care physician?
11. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ Yes ☐ No
12.
13. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ Yes ☐ No
14. Do you smoke or chew tobacco products? ☐ Yes ☐ No
15. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? ☐ Yes ☐ No
16. Are you nervous during dental treatment? ☐ Yes ☐ No
17. Rate your smile from 1 (poor) to 10 (excellent). If you could change anything about your smile, what would it be?
18. What are your hobbies or interests? What do you do for work?

Referral Information

Whom may we thank for referring you to our practice? ☐ another patient, friend/relative (Name) ______________________

☐ Dental office ☐ Yellow pages ☐ Newspaper ☐ School ☐ Work ☐ Other ______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I certify that I have answered all questions in this form accurately and to the best of my knowledge. I have read the above conditions of treatment and payment and agree to their content.

______________________ Signature of patient, parent or guardian

______________________ Date