FAMILY DENTISTRY

Howard R. Daines, DDS
Daniel K. Nelson, DDS
104 W 200 S Brigham City, UT
435-734-2394

Date: _____

Patient: _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

Birth Date: _____ Employer (or School) _____ SSN: _____ Cell #:_____

Responsible Party:_____ ☐ Father ☐ Mother ☐ Guardian ☐ Other

Birth Date: _____ Phone #: _____ Cell #: _____

_____ (Please initial). I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

Street Address: _____

City:_____ State: _____ Zip: _____

Is there anyone we can thank for referring you to our office?_____

Previous Dentist:_____ Time Since Last Visit:_____

Emergency Contact:_____ Phone #:_____

Primary Insurance:_____ Employed by: _____

Employee Name:_____ SSN or ID#_____ Group #_____

Birth Date:_____ Work #:_____

Do you have a secondary insurance? ☐ Yes ☐ No

Health History: (All items will be handled in a confidential manner). Please circle if you have or had any of the following:

Heart Problems/Murmur	High Blood Pressure	Arthritis	Stroke
Diabetes	Hepatitis/Liver Disease	Respiratory Disease	Ulcer
Artificial Valves/Joints	HIV/AIDS	Tuberculosis	Asthma
Rheumatic Fever	Bleed/Bruise Easily	Kidney Problems	Fainting

Other not listed: _____

Tobacco Use? ☐ Yes ☐ No
Women: Are you Pregnant/or Nursing?
Allergies or allergic reactions? _____

Please list any Medications you are taking, (Name and Purpose). Including birth control or Herbal remedies.

_____

_____

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change in medications or medical condition can affect dental treatment, I agree to notify the office of any changes at subsequent appointments.

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

(OVER►)

PATIENT'S NAME: _____

Consent to Proceed: I authorize the Dentist and/or such associates or assistants as he may designate to perform those procedures 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 pharmaceutical agents, 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, and temporary or rarely, permanent numbness, and muscle soreness.

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.

Signature:_____ Date:_____

Office Financial Policies and Federal Truth-in-Lending Statement

In consideration for the professional services rendered to me, or for my minor child or ward, I agree to pay the reasonable value of said services at the time services are rendered or within thirty (30) days of billing if credit is extended. I further agree that the value of said services shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I agree to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed to me, including charges or commissions up to 40% that may be assessed to us by any collection agency retained to pursue this manner.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be assessed on accounts exceeding sixty (60) days from the date of service, unless previously written, or agreed upon financial arrangements are satisfied.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment. This office will prepare and submit insurance forms and assist in making collection from insurance companies. Any such collections received will credit 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.

I authorized assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plans to this office.

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

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

REV 06/17