YOUNG FAMILY DENTAL, INC.

Patients Name _____ (First / Middle / Last) Birthdate _____ Age _____

Social Security # _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Separated ☐ Divorced

Address _____ (Street # / City / ST / Zip)

E-Mail Address _____

Employer _____ Occupation _____

Home Phone _____ Cell Phone _____ Work Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

Referred by: (circle) Phone Book | Insurance | Fair | Home Town Value | Direct Mail

Newspaper | Internet | Referral _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

Primary Insurance (Show identification card)

Insured's Name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____ Work # _____ Occupation _____

Insurance Company _____ Group # _____ Insurance ID # _____

Additional Insurance (Show identification card)

Insured's Name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____ Work # _____ Occupation _____

Insurance Company _____ Group # _____ Insurance ID # _____

FINANCIAL ARRANGEMENTS:

For your convenience we offer the following methods of payment. Payment in full is expected at each appointment.

Preference of Payment: ☐ Cash Credit Card ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover ☐ Care Credit

FINANCIAL RESPONSIBILITY:

By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand it is my responsibility to provide my correct/updated insurance information and this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I understand the entire amount owed is my full responsibility whether or not insurance pays any/and/or all portions of the amount owed. I understand if the amount owed is not paid within 30 days, interest will accrue at the rate of 18% per annum (1.5% per month) until paid in full. Further, I understand if any amount owed is not paid and referred to a third party for collection, the amount owed will be increased by 40% as a collection fee, in addition to any interest incurred to date, as allowed by Utah Code Annotated, sec. 12-1-11 we agree to pay all attorney's court costs, filing fee's and all collection costs. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for which I have legal responsibility whether such amount(s) are incurred today or at a later date. Minimum monthly fiance charge is $3.00. A $20.00 charge will be assessed on any returned checks.

INSURANCE RELEASE:

I understand and agree that dental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. Dr. Young's office only estimates the insurance co-payment. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also assume responsibility to inform Dr. Young's office of benefits that may have been paid to another office during the plan year so that yearly maximums can be determined. I hereby authorize release of any information, including diagnosis and records of any treatments or examinations rendered, charges billed, payments made, and interest charges assessed, etc. to my insurance company or companies or any other agency necessary for the collection of this account. I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted. This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor of insurance benefits under which I am entitled. This authorization is considered to be effective for present and all future insurance claims and supersedes all prior arrangements signed.

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.

Signature _____ Date _____

DENTAL / MEDICAL HISTORY (Confidential)

HEALTH INFORMATION: Please indicate YES or NO

Are you in good health?	____	____
Do you presently have pain?	____	____
Are you under a physician's care now?	____	____
Have you ever had:		
Abnormal heart condition?	____	____
Artificial valve?	____	____
Rheumatic fever or Rheumatism	____	____
Used Fen phen?	____	____
Diabetes?	____	____
Abnormal bleeding?	____	____
Artificial joint?	____	____
Unusual reaction to any drug or local anesthetic?	____	____
Oral Contraceptives (Antibiotics render oral contraceptives ineffective)	____	____
Have you ever used Osteoporosis drugs? (e.g. Actonel, Fosamax, Boniva, ect.) May result in complications or non-healing following oral surgery or extractions.	____	____

Please indicate YES or NO

Tuberculosis?	____	____
Radiation treatment?	____	____
Abnormal blood pressure?	____	____
Hepatitis or liver disease?	____	____
Blood transfusion? (give date)	____	____
AIDS or HIV positive?	____	____
Allergies?	____	____
Asthma?	____	____
Jaw joint pain, clicking, popping	____	____
Females, are you pregnant?	____	____
Is there any other information about your health that should be known?	____	____

List current Medications _____

_____

_____

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

Signature _____ Date _____

INFORMED CONSENT & CONSENT TO PROCEED:

I authorize Dr. Young and/or such associates or assistants as 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 those related to restorative, palliative, therapeutic or surgical treatments. arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical including agent(s),

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, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of 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. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. After lengthy appointments, jaw muscles may also be sore or tender. 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.

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 for 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.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

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

CONTACT RELEASE:

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf. I understand and agree such calls may be initiated Young Family Dental or any affiliates, agents, contractors or assigns, including by not limited to billing companies and/or third party collection agency(ies), and the methods of contract may include using pre-recorded voice messages and/or the use of an automated dialing device or text message (some of which may result in data charges). I also consent to receiving emails at any email address provided by me or anyone associated with me or acting on my behalf.

Signature _____ Date _____
patient or legal guardian

Notice of privacy practices can be obtained from the receptionist.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.