YOUNG FAMILY DENTAL, INC.

Child's Name_____
First Middle Last

Birthdate _____ Age _____ Male ____ Female ____ Who accompanied child today?_____

Parent or Guardian Information: _____ Parent _____ Step-parent _____ Legal Guardian

Name_____
First Middle Last

Address_____
CITY STATE ZIP

Birthdate _____ Age _____ Social Security#_____

Male _____ Female _____ Single _____Married _____Separated _____Divorced _____ Widow[er] _____

Home Phone _____ Cell Phone _____ E-Mail _____

Employer _____ Occupation _____ Work# _____

Where do you prefer to receive calls? Home _____ Work _____ Cell ____

Primary Insurance: (Show identification card) _____

Insured's Name _____ DOB_____ Relationship _____

Insurance Company _____ Group # _____ Insurance ID # _____

Employer _____ Occupation _____ Work# _____

Secondary Insurance: (Show identification card) _____

Insured's Name _____ DOB_____ Relationship _____

Insurance Company _____ Group # _____ Insurance ID # _____

How did you hear about us? (circle one): Insurance Proximity Direct Mail Online Search Referred by _____

Preferred method of payment: Cash ____ or Credit: ___Visa ___Mastercard ___ American Express ___ Discover ___ Care Credit

FINANCIAL ARRANGEMENTS: Payment in full is expected at each appointment. Insured patients are expected to pay their deductibles and/or their percentage or co-payments at the time of treatment. For your convenience we accept Visa, Mastercard, Discover, American Express and Care Credit. Minimum monthly finance charge is $3.00. A $20.00 charge will be assessed on any returned checks.

In the event of default in payment, a service charge of 1.75% per month (21% per annum) on the unpaid balance will be assessed. Should your account be referred out for collection, please be advised that in addition to all other amounts that may be due, you agree to pay a collection fee of up to 40% of the principal amount as provided by §12-1-11 of the Utah Code Annotated. You further agree to pay all other costs of collection (whether incurred by Young Family Dental, Inc. or its assigns) including but not limited to court costs, reasonable attorney fees, and interest (both pre-and post-judgment). Any interest due hereunder shall be calculated at a rate equal to 18% per annum and may, as determined by Young Family Dental or its assigns: (a) accrue on some or all amounts due and (b) compound as frequently as daily--meaning that accruing interest may be added to the balance owing as frequently as daily such that it shall thereafter constitute part of the amount upon which interest accrues during the next accrual period.

I hereby consent to being contacted by telephone at any phone number (including but not limited to wireless/cellular phone numbers) provided to Young Family Dental, Inc., by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by Young Family Dental, Inc., or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency[ies], and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails under the same terms at any e-mail address provided by me or anyone associated with me or acting on my behalf. In granting all of the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.

Signature _____ Date _____

DENTAL / MEDICAL HISTORY (Confidential)

_____

DENTAL INFORMATION: **YES / NO** **YES / NO**

Are you currently experiencing pain? ..... ____ ____ Jaw joint pain, clicking, popping ..... ____ ____

Are you allergic to latex? …….. ____ ____ Please list all other allergies below.

What is your biggest fear when coming to the dentist? _____

How can we make your visit more comfortable for you? _____

What is most important to you when visiting the dentist? _____

What would you like to change about your smile? _____

HEALTH INFORMATION: **YES / NO** **YES / NO**

Are you in good health?..... ____ ____ Are you under a physician's care now? ..... ____ ____

Have you ever had:

Abnormal heart condition?..... ____ ____ Abnormal blood pressure?..... ____ ____

Have you ever used Osteoporosis drugs? (e.g. Actonel, Fosamax, Boniva, etc.)..... ____ ____

Abnormal bleeding?..... ____ ____ AIDS or HIV positive?..... ____ ____

Artificial valve?..... ____ ____ Artificial joint?..... ____ ____

Asthma, or other respiratory problems?..... ____ ____ Diabetes?..... ____ ____

Blood transfusion? ..... ____ ____ Hepatitis or liver disease? ..... ____ ____

Radiation treatment?..... ____ ____ Rheumatic fever or Rheumatism ..... ____ ____

Tuberculosis?..... ____ ____ Used Fen phen?..... ____ ____

Do you have sleep apnea?..... ____ ____ Do you use a mouth appliance?..... ____ ____

Unusual reaction to any drug or local anesthetic? ... ____ ____ Do you have a disability?..... ____ ____

Are you currently pregnant?..... ____ ____ Do you take Oral Contraceptives?..... ____ ____
(Antibiotics can render oral contraceptives ineffective)

Is there any other information about your health that should be known?..... ____ ____

YES ANSWERS, please give dates and explanations (Please detail any disabilities).

_____

_____

_____

_____

List all current Medications:

_____

_____

_____

List all allergies:

_____

_____

INSURANCE RELEASE: I understand and agree that dental insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand, as a courtesy to me, Young Family Dental will provide me an estimate for the insurance co-payment. I also understand Young Family Dental will provide me with any necessary reports and forms to assist me in making a claim for collection from the insurance company. I understand any amount authorized by the insurance company to be paid on my behalf will be paid directly to this office and credited to my account upon receipt. Any funds paid directly to me by the insurance company will be turned over immediately to Young Family Dental to credit to my account. 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 Young Family Dental of benefits which may have been paid to another office during the plan year so that yearly maximums can be determined. I hereby authorize the 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 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 which require such information to be submitted. This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor of any insurance benefits under which I am entitled. This authorization is considered 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 all pages of this form accurately and to the best of my knowledge.

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 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, 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.

Signature _____ Date _____

To 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, please do not hesitate to ask, we are always happy to help