



# Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help you.

## Patient Information: (confidential)

SS#/SIN: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Sex: Male / Female

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Prov: \_\_\_\_\_ Zip/P.C.: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you prefer to be contacted via:  Cell Phone  Text  Email  Home Phone  Work Phone

Check appropriate box:  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  Full Time  Part Time

Patient or Parent/Guardian's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse or Parent/Guardian's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Driver's License# \_\_\_\_\_ Birthdate: \_\_\_\_\_ Financial Institution: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment due in full at each appointment:  Cash  Credit Card  Personal Check  Care Credit

## Insurance Information

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#/SIN: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit: \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No IF YES COMPLETE THE FOLLOWING:

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#/SIN: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit: \_\_\_\_\_

**Payment is due in full at the time of treatment** unless prior arrangements have been approved. This office accepts insurance; I understand that I am responsible for payment of services rendered and also responsible for paying deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I verify any information that I have given today is correct to my best knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X

Signature

Date

# Patient Medical History

Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

	Yes	No		Yes	No	
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	<b>10. Are you allergic to or have you had any reactions to the following?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>		Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non prescription medicine? If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>		Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>		Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel, or any bone density medications (bisphosphonates)?	<input type="checkbox"/>	<input type="checkbox"/>		Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>		Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>		Iodine	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>		Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>		Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
				Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____			
			<b>11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting 3 weeks)?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
			<b>12. Women Only:</b>			
			Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
			Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	
			Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No		Yes	No		Yes	No
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Growths	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replace / Implant	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Codeine Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolaps	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin Allergy	<input type="checkbox"/>	<input type="checkbox"/>			

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No
Do you gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Are you teeth sensitive to sweets, hot/cold liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you commonly use Soda's or Energy drinks?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any sores or lumps in/near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any difficult extractions?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw?			If yes, date of placement _____		
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience Dry Mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing/chewing	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>



Dr. Randal L. Hadfield  
3300 North Running Creek Way  
Building C Suite 100  
Lehi, Utah 84043  
(801)768-4072

### Financial Agreement

Thank you for choosing Dr. Hadfield as your dental care provider. The following is a statement of our financial agreement, which we require everyone to read and sign prior to any treatment. As a condition of your treatment by this office, please understand that payment of your bill is also considered a part of your treatment.

- \* Payment is due in full at time of service.
- \* Insurance holders: Patient portion is due at time of service. Any estimate given is not definitive.
- \* We accept **Cash, Check, Debit Cards, Credit Cards, and CareCredit.**
- \* We provide interest free payment plans through Care Credit that provides interest free payments on approved credit for up to twelve months.
- \* We require your account to be paid in full within 60 days. If there is a remaining balance after 60 days, a monthly charge of 1.5percent(18%APR) and a \$5.00 late fee will be added to your account every month.

### INSURANCE

Your insurance policy is a contract between you and your insurance company. We bill the insurance as a service to our patients; however, you are responsible to know your own benefits and coverage. Please be aware that you are responsible for all services not covered or paid by your insurance company. We cannot be held responsible for what your insurance chooses to cover or not cover.

### USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment possible for our patients and charges what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

### MISSED APPOINTMENTS

I understand that I will be assessed a minimum \$30.00 fee per half hour for failure to keep an appointment or notify the dental office of a cancellation 24 hours in advance. Our intent is not to add financial burden, but to improve accessibility to patients desiring dental care.

### DELINQUENT ACCOUNTS

In the event that my account becomes delinquent and my account is referred to a third party debt collection agency, I agree to pay the remaining balance plus the sum of the 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 your office that you may telephone me at home or at my workplace to discuss matters related to this form. I have read the entire **Financial Agreement** and have had sufficient time to study and understand it, or obtain legal counsel, if I so desire. I hereby agree to be bound by all of the foregoing terms and conditions outlined hereon. In the event that the terms of this agreement are not met, I agree to pay the principal amount, plus all attorney's fees, court costs, all costs of collection, including 40% of the principal amount turned over to our collection law firm in accordance with Utah Code Annotated, sec. 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.

**Signature of patient or responsible party** \_\_\_\_\_

**Date** \_\_\_\_\_

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## Section A: PATIENT GIVING CONSENT

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

## Section B: TO THE PATIENT-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:

Contact Person: Dr. Randal L Hadfield

Telephone: 801-768-4072

E-mail: hadfielddentalcare@gmail.com

Address: 3300 North Running Creek Way Bldg C #100, Lehi, UT 84043

**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

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and you 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 \_\_\_\_\_

Representative \_\_\_\_\_ Date \_\_\_\_\_