Ridge Line Dental
2185 N 1700 W #202
Layton, UT
(801) 773-5460

PATIENT REGISTRATION

(Please Print)

Today's date: / /

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status ❑Single ❑ Mar ❑Div ❑Sep ❑Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )	Cell phone no.: ( )

City	State:	Zip Code:	Social security no.:

Occupation:	Employer:	Employer phone no.: ( )

Is it OK to call work? ❑ Yes ❑ No	Referred by:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Name of primary insurance:				
Primary subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Member ID no.:	Group no.:
Primary subscriber's employer:				
Patient's relationship to primary subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):				
Secondary subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Member ID no.:	Group no.:
Patient's relationship to secondary subscriber:	❑ Self	❑ Spouse	❑ Child	❑Other
Secondary subscriber's employer:				

Do you have Medicare Part B? ❑ Yes ❑ No
Who was your previous dentist?
Is it OK if we contact your previous dentist about x-rays? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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MEDICAL HISTORY

Are you now or have been under a physician's care with the past year? ❑ Yes (*if yes, please specify*) ❑ No

Please mark if you have you ever had the following:
❑ Rheumatic fever ❑ Asthma ❑ Diabetes ❑ Rheumatism ❑ Arthritis ❑ Tuberculosis
❑ Venereal disease ❑ Heart attack ❑ Kidney disease ❑ Blood disorders ❑ Immune system disorder ❑ Other (*please specify*)

Do you take any medication? (Including birth control pills.) ❑ Yes (*if yes, please specify*) ❑ No

Are you taking any natural products, herbal supplement, tea, or other natural or homeopathic remedy? ❑ Yes (*if yes, please specify*) ❑ No

Please mark if you have you ever had an allergic reaction to the following:
❑ Penicillin ❑ Aspirin ❑ Acetaminophen ❑ Ibuprofen
❑ Codeine ❑ Sulfa drugs ❑ Barbiturates ❑ Other (*please specify*)

Please mark if you have ever taken any drug prescribed to decrease the resorption of bone as in osteoporosis or bone therapy:
❑ Fosamax ❑ Actonel ❑ Boniva ❑ Aredia ❑ Benefos ❑ Dironel ❑ Zometa ❑ Other (*please specify*)

Name of present physician:

Do you have or have you had any heart or blood problems? ❑ Yes (*If yes, please specify*) ❑ No

Have you ever been told you have a heart murmur? ❑ Yes ❑ No
Do you require antibiotic premedication? ❑ Yes ❑ No

Do you require antibiotic premedication for a heart condition or artificial valve? ❑ Yes ❑ No

Do you require antibiotic premedication for an artificial joint? ❑ Yes ❑ No

Have you ever taken the diet pill Phen-Fen? ❑ Yes ❑ No
Do you require antibiotic premedication? ❑ Yes ❑ No

Do you have or have you ever had high blood pressure? ❑ Yes ❑ No

Have you ever been diagnosed as being HIV positive or having AIDS? ❑ Yes ❑ No

Have you ever had hepatitis or liver disease? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No

Are you subject to fainting? ❑ Yes ❑ No

Do you bleed or bruise easily? ❑ Yes (*If yes, please specify*) ❑ No

Have you ever had any severe reaction to dental treatment or local anesthetics? ❑ Yes (*If yes, please specify*) ❑ No

Are you allergic to any local anesthetic? ❑ Yes (*If yes, please specify*) ❑ No

Do you have any other allergies? ❑ Yes (*If yes, please specify*) ❑ No

Have you ever had a nervous breakdown or undergone psychiatric treatment? ❑ Yes (*If yes, please specify*) ❑ No

Have you ever received counseling for excessive use of alcohol and/or prescription drugs? ❑ Yes (*If yes, please specify*) ❑ No

Do you consider yourself in good health? ❑ Yes ❑ No (*If no, please specify*)

Are you currently experiencing any pain from your teeth or gums? ❑ Yes (*If yes, please specify*) ❑ No

Do you have or have you ever had bleeding or sensitive gums? ❑ Yes (*If yes, please specify*) ❑ No

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HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

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.

I authorize Dr. Chaston, Dr. Namazi 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 limit to, bruising, hematoma, cardiac stimulation, muscle soreness and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of dental treatment including preventive procedures such as cleanings, basic dentistry, and fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. 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. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

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.

Patient/legal guardian signature, or authorized agent of patient *Date*

OFFICE USE ONLY:

Witness signature *Date*

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OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

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

A **finance charge of 1 ½ % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service. A **credit report** will be generated on each new patient that is offered payment arrangements. A credit report may also be generated on established patients, prior to extending payment arrangements, Payment history with our office will be taken into consideration when establishing payment arrangements. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, or at my request, to my minor child or ward by the dentist, I agree to pay the fees charged for the dental services provided to the dentist or his assignee at the time the services are rendered, or within five (5) days of billing if credit shall be extended. I agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. 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 you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

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 is null and void. I authorize Dr. Chaston, Dr. Namazi 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.

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

Patient/legal guardian signature, or authorized agent of patient *Date*

OFFICE USE ONLY:

Witness signature *Date*

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment plan and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/legal guardian signature, or authorized agent of patient *Date*

OFFICE USE ONLY:

Witness signature *Date*

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FOR PATIENTS WHO HAVE DENTAL INSURANCE

Patients who have dental insurance should understand that all professional services rendered are charged directly to the patient, and that he or she is personally responsible for these services. The obligation of fees exists as a contract between the insurance carrier and patient and not as an obligation of insurance companies to the doctor.

We will prepare and file, at no cost, any necessary insurance reports and claim forms for the insurance(s). However, we cannot render services on the assumption that the charges will be paid by an insurance company(s). Most confusion about insurance can be avoided if you understand exactly what specific benefits and limitations your particular policy(s) provides. Please understand there are many insurance companies and many types of policies and we cannot keep track of all of them. If you are not sure of the details, please check with your agent, company, or employer.

If for some reason the insurance claim (s) does not reach the proper channels, the responsibility to see that the bill is paid still rests on the patient. If a bill goes unpaid for 60 days, an interest charge of 18% annual rate will be applied to the patient's account. If this bill is still unpaid at 120 days, the account will be transferred to a collection agency. It will be the patient's responsibility to cover any attorney fees and collection agency's fee.

SIGNATURE: _____ DATE: _____
(Patient, legal guardian or authorized agent of patient)

WITNESS: _____ DATE: _____