Welcome to Our Office!

Patient Registration

Paul S. Jackson, D.M.D.

1345 E. Fort Union Blvd.
Salt Lake City, Utah, 84121

Patient's Name_____ Birth Date_____ Age_____ Gender____

Home Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____ SSN _____

Responsible Party _____ Relationship to Patient_____ Birth Date _____

Employer_____ Occupation_____ Work Phone_____

Email Address _____ Facebook? Y N

If Patient is a Minor:

Mother's Birth Date_____ SSN_____ Father's Birth Date _____ SSN _____

Emergency Contact Information:

Name_____ Address _____ Phone Number_____

How did you hear about our office? _____

Reason for your visit today? _____

Dental Insurance Information (Primary Carrier)	If you are double insured, complete this section.
Insured's Name:	Insured's Name:
DOB: SSN#	DOB: SSN#
Employer:	Employer:
Insurance Company:	Insurance Company:
Insurance Co. Address:	Insurance Co. Address:
Phone #	Phone #
Group # ID#	Group # ID#

_____ _____ _____

Name (Please Print) Patient Signature (Parent of Child) Date

Dental History

Please check any of the following that apply to you.	**Yes**	**No**
Sensitivity (hot, cold, sweet)	☐	☐
Where?		
Upper Left, Upper Right, Lower Left, Lower Right		
Headaches, ear aches, neck pain	☐	☐
Jaw joint pain	☐	☐
Teeth or fillings breaking	☐	☐
Grinding or clenching teeth	☐	☐
Bleeding, swollen, or irritated gums	☐	☐
Loose, tipped, or shifting teeth	☐	☐
Bad Breath	☐	☐

Do you have, or have you had, any of the following?

Dentures	☐	☐
Braces	☐	☐
Gum Treatments	☐	☐

Do you smoke or use chewing tobacco? Y N
How much? For how long?

	Yes	**No**
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐

If I could change my smile, I would:

Make my teeth whiter	☐	☐
Make my teeth straighter	☐	☐
Close spaces	☐	☐
Replace metal fillings with white ones	☐	☐
Repair chipped teeth	☐	☐
Replace missing teeth	☐	☐
Replace old crowns that don't match	☐	☐
Have a smile makeover	☐	☐

On a scale of 1-10, with 10 being the highest:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Please estimate the following dates:
When was your last cleaning? _____
Your last oral cancer screening? _____
Your last complete x-rays? _____

Previous Dentist Name: _____
City _____ State _____
Phone Number: _____

Why did you leave your previous dentist? _____
_____
_____

What is the most important thing about your visit today?
_____

What is The most important thing about your future smile and dental health? _____

Medical History

Please Check any of the following that may apply to you:

☐ Allergies	☐ Diabetes	☐ Heart Surgery	☐ Nervousness/Depression	☐ Stroke
☐ Anemia	☐ Dizziness	☐ Hepatitis A	☐ Pacemaker	☐ Thyroid Disease
☐ Arthritis	☐ Drug Addiction	☐ Hepatitis B	☐ Phen Fen (1 month +)	☐ Tuberculosis
☐ Artificial Heart Valve	☐ Emphysema	☐ Hepatitis C	☐ Radiation (head/neck)	☐ Ulcers
☐ Artificial Joints	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Respiratory Problems	☐ Venereal Diseases
☐ Asthma	☐ Fainting	☐ Jaundice	☐ Rheumatic Fever	☐ Other_____
☐ Blood Disease	☐ Glaucoma	☐ Kidney Disease	☐ Rheumatism	**Women Only:**
☐ Bruise Easily	☐ Heart Conditions	☐ Liver Disease	☐ Scarlet Fever	☐ Birth Control
☐ Cancer	☐ Heart Lesions	☐ Low Blood Pressure	☐ Seizures	☐ Breast Feeding
☐ Chemotherapy	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Stomach Problems	☐ Pregnant

Do you have any of the following drug allergies?

☐ Aspirin	☐ Nitrous Oxide
☐ Darvon	☐ Penicillin
☐ Erythromycin	☐ Percodan
☐ Local Anesthetic	☐ Valium
	☐ Other_____

Are you under a physician's care? What for?
_____
_____
Medications_____
_____
Physician _____ Phone_____

CONSENT TO PROCEED

I authorize Dr. Jackson and/or such associates or assistants as s/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 sedation (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, 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 the 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. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. 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 jaw bones 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 Name: _____

Signature:_____ Date:_____

(Patient, legal guardian or authorized agent of patient)

Office Financial Guidelines
Truth In Lending Statement

As a courtesy, we will be happy to assist you in filing your insurance claim. We will estimate as closely as possible your benefits, and you are asked to pay your deductible/co-payment when services are rendered. Your insurance is a contract between you, your employer and the insurance company, as such the obligation of full payment is with the responsible party. _____(Initial)

All major treatment and treatment involving a laboratory procedure (crowns, dentures, ortho appliances, etc.) will require an appropriate down payment. Charges may also be made for broken appointments and appointments cancelled without 24 hours' notice. _____(Initial)

As a condition of your treatment by Meadowbrook Dental, 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.

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 by the dentist or licensed employee at the time the services are rendered, or before time of services are rendered. If payment arrangements are necessary, I understand I may choose to apply for Care Credit before any other payment options are considered. If for any reason no payments are made after the first sixty (60) days, you will be charged your monthly payment plus a 2% late fee. In the event my account becomes delinquent, I agree to allow this charge to be made by Meadowbrook Dental. If your card is denied your account will be sent to the collections agency. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for 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 you or your assignee to telephone me at home/cell or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

I acknowledge that I have received a copy of this financial arrangement. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my finances.

Patient Name: _____

Signature:_____ Date:_____

(Patient, legal guardian or authorized agent of patient)

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

Signature:_____ **Date:**_____

(Patient, legal guardian or authorized agent of patient)