RIVERTON DENTAL

David Patch, D.D.S.

Patient Information

Patient Name: _____ M / F

Date of Birth: ____/____/____ SS#: _____

Address: _____
Street Apt #

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

Occupation: _____

Email Address: _____

Spouse Information

Name: _____

Home #: _____ Cell #: _____

Employer: _____

In the event of emergency: (Friend or Relative not living with you)

Emergency Contact: _____ #: _____

Relationship to patient: _____

Whom may we thank for referring you? _____

Dental Insurance

Primary Dental Insurance: _____

Phone #: _____ Plan Type: PPO HMO

Address: _____

Member #: _____ Group #: _____

Insured Name: _____ SS#: _____

Insured Birth Date: _____ Relation: _____

Secondary Dental Insurance: _____

Phone #: _____ Plan Type: PPO HMO

Address: _____

Member #: _____ Group #: _____

Insured Name: _____ SS#: _____

Insured Birth Date: _____ Relation: _____

Person Responsible for Dental Account

Name: _____

Address: _____

Home #: _____ Cell #: _____

Email: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under a physician's care?	Yes	No	If yes, _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, _____
Have you ever had a serious head or neck surgery?	Yes	No	If yes, _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, _____
Do you take or have you taken Phen-Fen or Redux?	Yes	No	If yes, _____
Have you ever taken Fosamax, Boniva, Actonel or a other medications containing bisphosphonates?	Yes	No	If yes, _____
Are you on a special diet?	Yes	No	If yes, _____
Do you smoke or use tobacco?	Yes	No	If yes, _____
Do you snore,have Sleep Apnea, or have a CPAP?	Yes	No	If yes, _____

Women: are you....

- ▫ Pregnant/Trying to get pregnant?
- ▫ Nursing?
- ▫ Taking oral contraception?

Are you allergic to any of the following?

- ▫ Aspirin
- ▫ Penicillin
- ▫ Codeine
- ▫ Acrylic
- ▫ Metal
- ▫ Latex
- ▫ Sulfa Drugs
- ▫ Local Anesthetic
- ▫ Other? Explain: _____

Do you use controlled substances? Yes No If yes, _____

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

AIDS/HIV	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatment	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Out of Breath	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Shingles	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disorder	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sinus Troubles	Yes	No
Asthma	Yes	No	Fainting/Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chest Pain	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tumors	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joint	Yes	No	Ulcers	Yes	No
Congenital Heart	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed? Yes No If yes, _____

Comments:

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist.

Patient/Parent/Guardian Signature: _____ Date: _____

Office Financial Policy

At Riverton Dental, our first priority is to you as a patient. We are glad you have chosen Riverton Dental for your dental needs. We look forward to providing you with quality service and the best experience possible. To make this happen, we rely on your representation that you will pay our office for the services we provide. In hiring our office to provide you with dental services, you agree to the following terms:

1. **Courtesy insurance claims.** As a courtesy we will be glad to file your claim if you bring 1) your dental insurance card 2) all required employer information. You will be expected to pay up front for services rendered if the office is unable to verify your insurance information before treatment.

2. **You are responsible to pay your entire bill.** Insurance benefits are determined by your insurance provider, not your dentist. Your insurance is a contract between you and your insurance company. Any deductible or estimated co-payment amount will be due at the time of treatment. Proof of insurance is not a guarantee of payment; insurance typically will not pay for all of your costs.

3. **Payment is due at the time services are rendered.** For your convenience we accept cash, Visa, Mastercard, Discover card, American Express, and personal checks, (prior to commencing treatment plans and financing arrangements can be made for most dental treatment by way of separate payment plan contract,. For your convenience outside financing is also available through Care Credit and Proceed Finance.)

4. **Return check fee**. Riverton Dental charges a return check fee of $25.00 for any check that is dishonored for any reason**.**

5. **Collections.** By signing below I agree to pay all amount(s) owed within 45 days of when amount(s) are incurred. I understand that it is my responsibility to provide my correct /updated insurance information and that the office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past- due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount is referred to a third party debt collection agency, I agree that in addition to any other amounts allowed by law, (such as interests,court costs, reasonable attorney fees, etc.) I will also be responsible for the collection fee of up to 40% of the principal amount owing allowed by the Utah Code Annotated, sec 12-1-11. The terms of the paragraph shall apply to all amounts incurred by me or any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

6. **72-Hour Cancellation Policy.** Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise. **Riverton Dental reserves the right to charge a $50.00 fee per hour reserved for any appointments that are missed/cancelled without 48-hours' notice.**

Patient name: _____ **Date: _____**

Signature: _____. **Relationship: _____**

CONSENT TO TREAT

I authorize Dr. David Patch, D.D.S. 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 unwanted 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. 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. 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 Fosanax, Boniva, 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. I understand that treatment has the possibility to change during the appointment time. If treatment changes for me and/or any minor or other individual for which I have responsibility, Riverton Dental will make reasonable effort to contact me to inform me of the changes. I have the option to accept or reject treatment at that time. If I am not reachable, I authorize Riverton Dental to proceed with treatment and I take full financial accountability for that decision.

- I also acknowledge that all of the preceding answers and information provided on all forms filled out are true and correct. If I ever have any change in my health or there are changes in my child's health, I will inform Riverton Dental at the next appointment without fail. If changes are not reported, I agree that any damage incurred will be my sole responsibility, financially, and legally.

- I acknowledge that I have the right to refuse treatment at which time I must sign the proper refusal forms. I agree that I will be responsible for any damage incurred if prescribed treatment is not rendered within the reasonable prescribed amount of time.

Patient's Name (please print) _____

Signature of Patient, Parent or Guardian (Print name if you're not the patient) _____

Date _____

Please Rate: 1= Low Priority/Importance 5= High Priority/Importance

Chewing Ability/Function

- 1 2 3 4 5

Aesthetics

- 1 2 3 4 5

Preventing Issues Before They Progress

- 1 2 3 4 5

Quality

- 1 2 3 4 5

Money/Value

- 1 2 3 4 5

Time/Convenience

- 1 2 3 4 5

Comfort

- 1 2 3 4 5

Trust

- 1 2 3 4 5

Oral Health/Overall Health

- 1 2 3 4 5