7138 South Highland Drive, Ste 214

Cottonwood Heights, Utah, 84121

801-942-7770

New Patient Welcome Forms

Full Name: _____ Date: _____

Birthdate:_____ Age: _____ SSN: _____

Marital Status: _____ Phone: _____ Cell: Y / N

Street Address:_____

City: _____ State: _____ Zip: _____

Email: _____ Text Okay: Y / N

Today's Appointment

Last Dental Visit (month, year): _____

Reason for Visit:

- ☐ Regular Cleaning and Exam
- ☐ Pain
- ☐ Straightening Teeth (Invisalign)
- ☐ Tooth Restoration (Implants)

Would like more information about:

- ☐ Whitening
- ☐ Straightening Teeth (Invisalign)
- ☐ Tooth Restoration (Implants, 3D X-ray)
- ☐ Sleep Dentistry, Laughing Gas
- ☐ Financial Options

Financial Information

Primary

Insurance Plan: _____ Group Number: _____

Subscriber Name: _____ Subscriber ID: _____

Relationship to Patient: _____ Subscriber DOB: _____

Insurance Contact Number: _____

Employer Name: _____ Employer Phone: _____

Secondary

Insurance Plan: _____ Group Number: _____

Subscriber Name: _____ Subscriber ID: _____

Relationship to Patient: _____ Subscriber DOB: _____

Insurance Contact Number: _____

Employer Name: _____ Employer Phone: _____

Responsible Party *if minor

Last Name: _____ First Name: _____ Middle Initial___

Street Address (if different):_____

City: _____ State:_____ Zip:_____

Phone Number (Cell): _____ (Home)_____ (Work) _____

Email: _____

Authorization:

I authorize and consent to diagnostic, preventative, and restorative dental care treated by my dentist, and to release information regarding my own, or my child's, health care, treatment, or advice to another dentist, and/or administering insurance claims for insurance benefits on my behalf. I consent to direct payment of my insurance benefits to my dentist or dental group. I acknowledge that my insurance benefits may not pay the full bill for services rendered to me. I am responsible for any services left unpaid or uncovered by my benefits and remaining account balances.

Electronic Communication:

I consent to the receipt of HIPAA-complaint electronic communications, which may be email or text message, regarding treatment, my prior health history, prescriptions, and/or payment information. Message/data rates do apply and I may opt out at any time.

Photo Image Use:

Authorization:

*By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the "**Patient**"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "**Images**"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that dental services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "**Information**"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.*

Purpose:

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

Expiration and Revocability:

If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re-disclosure of information.

Medical History

Physician's Name: _____ Date of Last Visit: _____

Historically, serious illness or operation (if so, what and when)?_____

Have you every had a blood transfusion (if so, when): _____

Could you be or are you pregnant?_____ Nursing?_____

Taking birth control? _____

Currently taking any medication? _____

Allergies:

Aspirin ☐	Local Anesthetic ☐	Latex ☐
Sleeping Medication ☐	Penicillin ☐	Other: _____
Codeine ☐	Sulfa ☐	

Check if you have any of the following:

Anemia ☐	Cortisone Treatments ☐	High Blood Pressure ☐	Skin Rash ☐
Arthritis, Rheumatism ☐	Cough ☐	HIV/AIDS ☐	Stroke ☐
Artificial Heart Valves ☐	Coughing Blood ☐	Jaw Pain ☐	Swelling Feet ☐
Artificial Joints ☐	Diabetes ☐	Kidney Disease ☐	Thyroid ☐
Asthma ☐	Epilepsy ☐	Liver Disease ☐	Swelling Feet ☐
Back Problems ☐	Fainting ☐	Pacemaker ☐	Tonsillitis ☐
Blood Disease ☐	Glaucoma ☐	Radiation Treatment ☐	Tuberculosis ☐
Chemical Dependency ☐	Heart Murmur ☐	Respiratory Infection ☐	Ulcers ☐
Chemotherapy ☐	Heart Problems ☐	Scarlet Fever ☐	
Circulatory Problems ☐	Hepatitis ☐	Shortness of Breath ☐	

Signature

To the best of my knowledge, the information above is complete, accurate, and correct. I acknowledge and understand my responsibility to inform my doctor if I, or my child, have a change in health.

Signature of Patient, Parent, Guardian, or Representative _____

Print Name _____ Relationship to Patient_____ Date_____