Dental Registration and History

Patient Information

Today's Date: _____
Name: _____
Preferred Name: _____
Gender: _____ ☐ Single ☐ Married ☐ Child ☐ Other
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Social Security Number: _____
Driver's License Number: _____
Emergency Contact: _____
Phone Number: _____
Relationship to Patient: _____
Closest Relative not living with you: _____
Phone Number: _____

Person Financially Responsible for Account

Name: _____
Gender: _____ ☐ Single ☐ Married ☐ Other
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____
Social Security Number: _____
Driver's License Number: _____
Spouse's Name: _____
Work Phone: _____
Landlord: _____
Phone Number: _____

Dental Insurance

The following questions are about the insurance subscriber(s):

PRIMARY INSURANCE

Subscriber's Name: _____
Date of Birth: _____
Phone Number: _____
SSN or Sub ID: _____
Relationship to Patient:
☐Parent ☐ Spouse ☐Other: _____
Dental Insurance Company: _____
Phone Number: _____
Employer: _____

SECONDARY INSURANCE

Subscriber's Name: _____
Date of Birth: _____
Phone Number: _____
SSN or Sub ID: _____
Relationship to Patient:
☐Parent ☐ Spouse ☐Other: _____
Dental Insurance Company: _____
Phone Number: _____
Employer: _____

Dental Information

Do your gums bleed when you brush? ☐ YES ☐ NO
Are your teeth sensitive to pressure? ☐ YES ☐ NO
Are your teeth sensitive to hot or cold? ☐ YES ☐ NO
Do you grind or clench your teeth? ☐ YES ☐ NO
Do you have a fear of the dentist? ☐ YES ☐ NO
Have you had your teeth bleached? ☐ YES ☐ NO
How do you feel about the appearance of your teeth?
☐ Love them ☐ Accept them ☐Want to change them
How do you feel about the appearance of your smile?
☐ Love it ☐ Accept it ☐Want to change it
Are you interested in Nitrous Oxide (Laughing Gas)?
(if minor, MUST have parental consent) ☐ YES ☐ NO
Date of Last Examination? _____
What was done at that time? _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, friend _____

☐ Another patient, relative _____

☐ Another Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Insurance

Acknowledgement with 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 medication can affect dental treatment, I understand the importance of and agree to notify the dentist of any change at any subsequent appointment.

I authorize ***Dr. Jesse N. Greaves*** and/or such associates or assistants as he may delegate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including Nitrous Oxide), analgesic, other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand the administration of local anesthetic may cause untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles may break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

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 preventative 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 as necessary and I have been given the opportunity to ask questions.

Signature of Patient, Parent or Guardian	Date	Relationship to Patient

Signature of Witness	Date

Holladay Family Dental

Holladay Family Dental

1548 East 4500 South
Suite 104
Salt Lake City, Utah 84117
(801) 272-8051

OFFICE POLICES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at time of service.

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients and 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 service charge of 1.5% per month (18% per annum) on unpaid balance will be assessed on all accounts exceeding sixty(60) days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for professional services rendered to me, or at my request for a minor child or ward, by the dentist, I agree to pay the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty(30) days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be billed unless objected by me in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% of principle) that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matter relating to this form. I further agree that if I cannot be contacted related to these matters my emergency contact(s) may be contacted, with utmost discretion, to ascertain my whereabouts.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Jesse N. Greaves, DMD. I certify that I have read and answered all questions on the forms accurately and hereby agree by all conditions outlined therein.

Signature of Patient, Parent or Guardian	Date	Relationship to Patient

Holladay Family Dental

1548 East 4500 South
Suite 104
Salt Lake City, Utah 841117
(801) 272-8051

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. By signing this form, you consent to our use and disclosure of Protected Health Information about you for Treatment, Payment and Healthcare Operations. You have the right to revoke this consent in writing.

I hereby give consent for Jesse N. Greaves, DMD to use my personal health information for Treatment, Payment and Healthcare Operations. (We will gladly provide you with a copy of the Notice of Privacy Practices for Jesse N. Greaves, DMD upon request.)

Patient's Name (please print): _____

Signature: _____ **Date:** _____

***If this is signed by a personal representative on behalf of the patient, complete the following:*

Personal Representative's Name: _____

Relationship to Patient: _____

Medical History

Patient's Name: _____ **Date of Birth:** _____

1. Do you have any current dental concerns? . . . . . YES NO
   If yes, please describe:
2. Are you having any pain or discomfort at this time? . . . . . YES NO
3. Have you been admitted to a hospital or needed emergency care during the past two years: . . . . . YES NO
   If yes, please explain:
4. Are you currently, or have you been in the last two years, under a care of a medical doctor? . . . . . YES NO
   Physician's Name: Phone Number:
5. Have you taken any medication or drugs in the past two years? . . . . . YES NO
6. Are you now taking any medication, drugs, or pills? . . . . . YES NO
   If yes, please list:
7. Are you currently taking any type of Herbal Supplements? . . . . . YES NO
   If yes, please list:
8. Have you taken the diet drug Phen-Phen? . . . . . YES NO
   If yes, have you seen your physician or cardiologist for a cardiac evaluation? . . . . . YES NO
9. Have you ever taken Fosamax, Actonel, Boniva, or any other drug(s) prescribed to decrease the resorption of bone, as in osteoporosis, or any drug(s) for metastatic bone cancer? . . . . . YES NO
10. Indicate which of the following you HAVE HAD or HAVE at the present. Check "yes" or "no" for each item.

Heart Disease or Attack	YES	NO	Thyroid Problems	YES	NO	Bruise Easily	YES	NO
Congenital Heart Disease	YES	NO	Glaucoma	YES	NO	Epilepsy or Seizures	YES	NO
*Heart Murmur	YES	NO	Cancer	YES	NO	Fainting or Dizzy Spells	YES	NO
High / Low Blood Pressure	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
*Artificial Heart Valve	YES	NO	Chemotherapy	YES	NO	Developmentally Disabled	YES	NO
Heart Pacemaker	YES	NO	Emphysema	YES	NO	Excessive Thirst	YES	NO
Heart Surgery	YES	NO	Chronic Cough	YES	NO	Alzheimer's Disease	YES	NO
*Rheumatic Fever	YES	NO	Tuberculosis	YES	NO	Blood Transfusion	YES	NO
Arthritis	YES	NO	Asthma	YES	NO	Any kind of Glandular Disorder	YES	NO
Cortisone / Steroid	YES	NO	Hay Fever	YES	NO			
Drug Addiction	YES	NO	Seasonal Allergies	YES	NO	Are you allergic to any of the following:		
Stroke	YES	NO	Hives	YES	NO	Aspirin	YES	NO
Blood Disease	YES	NO	Sinus Trouble	YES	NO	Codeine	YES	NO
Hemophilia	YES	NO	Shortness of Breath	YES	NO	Erythromycin	YES	NO
Anemia	YES	NO	Cold Sores / Fever Blisters	YES	NO	Nitrous Oxide	YES	NO
Sickle Cell Disease	YES	NO	Pain in Jaw Joints	YES	NO	Novacaine / Local Anesthetic	YES	NO
Hypoglycemia	YES	NO	Hepatitis	YES	NO	Penicillin	YES	NO
*Artificial Joints	YES	NO	Yellow Jaundice	YES	NO	Percodan	YES	NO
Kidney Trouble	YES	NO	Venereal Disease	YES	NO	Sleeping Pills	YES	NO
Ulcers	YES	NO	A.I.D.S	YES	NO	Tetracycline	YES	NO
Diabetes	YES	NO	H.I.V. Positive	YES	NO	Valium	YES	NO

11. Are you allergic or sensitive to any medication or anesthetics not listed above? . . . . . YES NO
    If yes, please list:
12. Do you have or have you had any disease, condition, or problem not listed above? . . . . . YES NO
    If yes, please list:
13. Do your ankles swell during the day? . . . . . YES NO
14. Have you lost or gained more than 10 pounds in the past year? . . . . . YES NO
15. Are you on a special diet? . . . . . YES NO
16. Do you use tobacco or alcohol products? . . . . . YES NO
17. Have you ever had any complications following dental treatment? . . . . . YES NO
    If yes, please explain:

FOR WOMEN ONLY:

18. Are you pregnant? YES NO If yes, what month: Are you nursing? YES NO
19. Are you taking birth control pills? . . . . . YES NO

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment with out fail.

_____ _____

Signature of Patient, Parent or Guardian Date Relationship to Patient