WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date ______________ Soc. Sec. # ______________ Birthdate ______________

Name ______________ (Last Name) ______________ (First Name) ______________ (Initial) Home Phone ______________

Address ______________ Cell Phone ______________

City ______________ State ______ Zip ______ E-mail ______________

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer ______________ Business Phone ______________

Business Address ______________ Occupation ______________

Who should we thank for referring you? ______________

In case of emergency, who should we contact? ______________ Phone ______________

PRIMARY DENTAL INSURANCE

Person Responsible for Account ______________ (Last Name) ______________ (First Name) ______________ (Initial)

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ______________ Home Phone ______________

City ______________ State ______ Zip ______

Responsible Party Employed By ______________ Business Phone ______________

Business Address ______________ Occupation ______________

Insurance Company ______________

Insurance Company Address ______________

Subscriber I.D. # ______________ Group # ______________

ADDITIONAL INSURANCE

Insured Name ______________ (Last Name) ______________ (First Name) ______________ (Initial)

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ______________ Home Phone ______________

City ______________ State ______ Zip ______

Insured Employed By ______________ Business Phone ______________

Insurance Company ______________

Insurance Company Address ______________

Subscriber I.D. # ______________ Group # ______________

Please complete reverse side

DENTAL HISTORY

Former Dentist ______________________

City, State ______________________

Date of Last Dental Visit ______________________

Date of Last X-Rays ______________________

How Often Do You Floss? ______________________

How Often Do You Brush? ______________________

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: ______________________

____

	Yes	No
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

	Yes	No
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type ______ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to ______________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________ Date ______________

OFFICE FINANCIAL POLICIES

- *All dental services performed must be paid for at the time the services are rendered.*

- *Patients who carry dental insurance understand that dental procedures will be billed to the insurance company at the time they are preformed as a courtesy from our office. Insurance benefits and treatment plans are an estimation only and are subject to change. This dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.*

- *We require 24 hours notice for cancellation of appointments. There will be a $25 charge for missed appointments or cancellations less than 24 hours in advance. This charge is not covered by insurance.*

- *By signing below I agree to pay all amount(s) owed within 30 days of the when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this 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 froth herein. I agree that interest still accrue on all past-due amounts at the rate Of 18% per annum (1.5% per month) until paid in full. In the event ant amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court cost, reasonable attorney's fees, etc.) I will also be responsible for a collection fee up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec 12-1-11. The terms of this legal paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.*

- *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. This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements.*

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

- *I also acknowledge that I have had the opportunity to review the office Privacy Policy Notice for*

  Dr Jacob D Finlinson D.D.S

______________________________	________	____________________
Signature of patient, parent or guardian	*Date*	**Relationship to patient**