# Three Fountains Dentistry

| | | | |
|---|---|---|---|
| **Patient Name:** | | Date: | |
| Family Status: | Male / Female | Spouse: | |
| Social Security Number/Driver's License: | | | Birthdate: |
| Phone (Home:) | (Mobile) | (Work) | Text Messages: Yes/No |
| Email Address: | | | Email Messages: Yes/No |
| Home Address: | | | |
| | | | |

## HEALTH HISTORY

Date of Last Dental Visit: _____ Reason for this visit: _____

- ☐ AIDS
- ☐ Allergies (Seasonal)
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Cough
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disease
- ☐ Cortisone/Steroid
- ☐ Developmentally Disabled
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Glandular Disorder (Any)
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV Positive
- ☐ Hives
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pain in Jaw Joints
- ☐ Pregnancy (Current)
- ☐ Due Date:
- ☐ Radiation Treatment
- ☐ Repiratory Problems
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Yellow Jaundice
- ☐ Venereal Disease

- ☐ **ALLERGIES:**
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex Gloves
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Novacaine
- ☐ Penicillin
- ☐ Percodan
- ☐ Sleeping Pills
- ☐ Tetracycline
- ☐ Valium

**Rx Medications Taking:**

_____
_____
_____
_____
_____
_____
_____

1 Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

2 Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

3 Do you require antibiotic pre-medication for a heart condition, aritifical valve or artificial joint? Yes No

4 Do you have any problems that need further clarification? Yes No

5 Do you have or ever had bleeding or sensitive gums? Yes No

6 Have you ever taken Phen-Fen or similar appetite suppressants? Yes No
If yes, have you seen your physician or cardiologist for a cardiac evaluation: Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of Patient, If Parent or Guardian (Relationship to Patient) Date

# Three Fountains Dentistry

## REFERRAL INFORMATION

Whom may we thank for referring you to our practice?
☐ Another Patient/friend ☐ Another Patient/Relative
☐ Another Dental Office ☐ Internet/Website ☐ Newspaper/Home Mailer ☐ Work
Name of person or office referring you to our practice: _____

## EMERGENCY CONTACT (Outside of Immediate Household)

Name: Relationship Phone Number

## Spouse or Responsible Party Information

The following is for: ☐ the patient's Spouse ☐ the person responsible for payment
Name: _____ Gender: M / F ☐ Single ☐ Married
Home Phone: _____ Work Phone: _____
Social Security Number: _____ Driver's License Number: _____
Address: _____

## EMPLOYMENT INFORMATION

The following is for ☐ The Patient ☐ The Personal Responsible for payment
Employer Name: _____
Address: _____

## INSURANCE INFORMATION

**Primary**

Name of Insured: _____ Is Insured a Patient? Yes / No
Insured's Birth Date: _____ Id#: _____ Group #: _____
Insured's Address: _____
Insured's Employer Name: _____
Address: _____
Patient's relationship to Insured: Self Spouse Child Other :

Insurance Plan Name and Address: _____



**Secondary**

Name of Insured: _____ Is Insured a Patient? Yes/No
Insured's Birth Date: _____ Id#: _____ Group #: _____
Insured's Address: _____
Insured's Employer Name: _____
Address: _____
Patient's relationship to Insured: Self Spouse Child Other:

Insurance Plan Name and Address: _____

# OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

**As a condition of your treatment by this office, 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.**

**All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash 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 or 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 monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.**

**In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by Dr. Mark Cannon or Dr. Jesse Greaves, 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 within five (5) days of billing if credit is extended by the dentist. 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 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 authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.**

**I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.**

**I certify that I have answered all questions pertaining to finances accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.**

_____ _____

**Signature of Patient, parent or guardian** **Date**

**Relationship to Patient**_____

(Rev.4/10)

*The interest rate charged may be at the discretion of your office or accountant.

# CONSENT TO PROCEED

I authorize Dr. Mark Cannon and Jesse Greaves 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 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 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. 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 reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental 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)

Witness:_____ Date:_____


# THREE FOUNTAINS DENTISTRY
4970 S. 900 E.
Salt Lake City, UT 84117

## 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 Dr. Jesse Greaves or Dr. Mark Cannon 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 Three Fountains Dentistry 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: _____