

FLAT RATE DOCTORS

Full Legal Name: _____ Preferred Name: _____

Birth Date: _____ Social Security: _____

Email: _____

Address: _____ City: _____ State _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Gender: _____ Marital Status: _____ Spouse Name: _____

College Status: Full-Time or Part-Time School Name: _____

Who is responsible for the payment on this account (Guarantor)? _____

Guarantor's place of employment _____

Children Name and Birthday: _____ Children Name and Birthday: _____

How did you find us? Google Search Facebook Magazine Event Drive By

Other/Referral Name: _____

Emergency Contact: _____ Phone: _____

Relationship to Emergency Contact: _____

How long since your last cleaning? _____

Please tell us what services you are interested in:

Dental Implant Wisdom Teeth Braces/Invisalign Dentures/Implant Dentures

Bone/Tissue Graft Replacing Silver Filling Crown/Root Canal

Other: _____

Do you have any dental concerns? _____

*As a Courtesy to our patients we will file claims to your insurance; however it is the patient/guarantor's responsibility to keep us informed of new changes with insurance. If no information is given you will automatically be responsible for all charges incurred at the date of your visit.

Policy Holder's Full Name: _____

Employer: _____ Policy Holder's Soc Sec: _____

DOB: _____ Ins. Company Name: _____

Address: _____ Customer Service Phone Number: _____

Member ID #: _____ Group #: _____

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MEDICAL HISTORY

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 under a physician's care now? Yes No

If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No

If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No

If yes, please explain: _____

Are you currently taking any medications, pills, or drugs? Yes No

If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you pregnant/Trying to get pregnant? Due Date _____ Nursing? Taking oral contraceptives?

Do you use controlled substances? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Metal Codeine Acrylic Local Anesthetics Latex Other

If yes, please explain: _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Herpes | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Lung Disease | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral Valve Prolapse | |

Have you ever had any serious illness not listed above?

If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ Date: _____

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Financial Arrangements

We are committed to providing you with the best possible care. If you have dental or medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, check and all major credit cards. We also accept Care Credit and Lending USA plans. Charges may also be made for broken appointments and appointments cancelled without a 24 hour advance notice. If you do not show up or if you cancel your appointment in less than 24 hours of it's scheduled time, you will be charged a \$50 fee. We will be happy to process your insurance claim. Any such request must be accompanied by a completed insurance form and any updates each visit. Returned checks and balances older than 30 days will be subject to a \$25.00 charge and additional collection fees.

We will gladly discuss your proposed treatment and answer any questions relating your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R" is defined as usual, customary, and reasonable.

This statement does not apply to companies that reimburse based on an arbitrary "schedule of fees", which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies that reimburse base on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

4. You will be fully responsible for any balance not paid by insurance 60 days after your claim has been submitted. You will receive a bill from us showing the outstanding balance. We will be happy to provide any documentation to help assist you in collecting reimbursement from your insurance company directly.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within 60 days of claim submission. I understand payment is due at the time of service. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. I will be responsible for any and all charges applied by the collection agency if this account must be turned over to collections. I understand that I will be responsible for any and all court and attorney fees. The undersigned agrees to pay a service charge of \$20 for each check or instrument tendered but returned unpaid. In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 40% of the unpaid balance, as allowed by Utah Code Annotated, sec. 12-1-11. In the event a lawsuit is brought to collect the unpaid balance, the undersigned further agrees to pay all other costs of collection, court costs and reasonable attorney fees, in addition to, the collection fee. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual whom I have legal responsibility whether such amount(s) are incurred today or after today. The undersigned further authorizes us or our agent to call any number provided or at any number at which we or our agent reasonably believes we can contact you, including calls to mobile, cellular, or similar devices for any lawful purpose. The terms and conditions contained within this agreement shall be governed by the laws of the State of Utah and shall be construed and interpreted in accordance with those laws. Any action or proceeding brought by either party which is based upon or derived from, or in any way related to this agreement, shall be brought in a

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court of competent jurisdiction within the state of Utah. The parties hereto consent to their personal jurisdiction of said court.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ Date: _____

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Insurance

I authorize release of information to all my insurance carriers.
I understand that I am responsible for any part of my bill not covered by my insurance.
I understand that I will be billed for treatment not paid by my insurance 60 days after claim submission.
I authorize payment directly to my doctor.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance.

Consent for Services

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon each diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required providing proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

CONSENT TO PROCEED

I authorize the Doctors at Flat Rate Dental and/or such associates or assistants as she/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 sedatives (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.

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 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.

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____