Welcome to Ashman Dental

Patient Name _____ Birth date_____

Address _____ City _____ Zip _____

Email _____ Home # _____ Cell # _____

Minor Single Married Divorced Widowed Separated

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ Zip _____

Birth date _____ Home # _____ Cell # _____

Is this Person Currently a Patient in our Office? Yes No

If you are working with a Dental Benefit, please give your card to the Receptionist. They'll be more than happy to copy the card for your records.

Name of Insured _____ Employer_____ Birthday_____

SS# _____-____-_____ Relationship to Patient _____

Name of Insurance Co. _____ Subscriber ID _____

Group # _____ Phone # _____

Address _____ City _____ Zip _____

Do You Have an Additional Dental Benefit? Yes No

Medical History:

Are you under medical treatment now? Or have you been hospitalized in the past 5 years? If yes, please explain: _____

_____

Are you currently taking any medication(s)? If yes, please list: _____

_____

Have you ever taken/used: Fen-Phen/Redux? Yes No Prescription for osteoporosis? Yes No Name of RX _____
Tobacco? Yes No A controlled substance? Yes No

Women only,
Are you: Pregnant? …. Yes No Possibly Nursing? …… Yes No

Do you have any allergies or reactions to any drugs or materials? If yes, please list. _____

(See Other Side)

Heart Conditions? Please Describe _____

Artificial Joints? Please Describe _____

Do you have or have you had any of the following? Please circle all that apply.

High Blood Pressure ***Heart Attack*** ***Rheumatic Fever*** ***Swollen Ankles*** ***Fainting/Seizures*** ***Asthma***

Epilepsy/Convulsions ***Leukemia*** ***Kidney Disease*** ***Aids/HIV Infection*** ***Thyroid Disease*** ***Heart Disease***

Cardiac Pacemaker ***Heart Murmur*** ***Angina*** ***Anemia*** ***Emphysema*** ***Cancer*** ***Arthritis***

Joint Replacement ***Hepatitis/Jaundice*** ***STD*** ***Easily Winded*** ***Stroke*** ***Hay fever/Allergies***

Tuberculosis ***Radiation Therapy*** ***Glaucoma*** ***Unexplained Weight Gain/Loss*** ***Liver Disease*** ***Heart Disease***

Respiratory Problems ***Mitral Valve Prolapse***

If circled yes, please explain:

_____

HIPPA

Acknowledgement of receipt of Notice of Privacy Practices. *YOU MAY REFUSE TO SIGN THIS* I _____ have received a copy of this office's Notice of Privacy Practices.

Signature_____ Date_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered; I understand that providing incorrect information can be dangerous to my health. I authorize Ashman Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Ashman Dental insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand, (regardless of my insurance status), that in the event of default of the above polices, I agree to pay all collection costs, but not limited to, reasonable attorney's fees, court costs, costs of preparing documents for court and collection agency fees up to 50% of unpaid balance, whether incurred by filing a lawsuit or otherwise.

_____

Signature Date

In the event that there is a problem with my insurance, I give Ashman Dental the permission to submit a complaint to the Utah Insurance Commissioner, D. Kent Michie.

_____

Signature Date