My Family DENTIST

EDDIE S. FADDIS, D.D.S.

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801-785-8835

GENERAL & COSMETIC DENTISTRY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name_____Date_____

Birth date_____/_____/_____ Social Sec. No. _____/_____/_____ Sex_____Male_____Female

Address_____

City_____ ST_____Zip_____Phone____-_____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____

Nearest relative not living with you:_____ Phone_____-_____

How were you referred to our office?_____

Account Information/Insurance

Person Financially Responsible_____
(if different than above)

Birth date_____/_____/_____ Social Sec. No._____/_____/_____

Employed: _____ Full time _____ Part time _____ Retired

Employer_____ Occupation_____

Employer Address_____Phone_____-_____

Spouse_____

Birth date _____/_____/_____ Social Sec. No. _____/_____/_____ Phone_____-_____

Spouse Employer_____ Occupation_____

Employer Address_____Phone_____-_____

DENTAL INSURANCE

Primary Dental Insurance_____

Group Name _____ Group Number_____

Address _____

City_____ ST_____Zip_____Phone____-_____

Secondary Dental Insurance_____

Group Name _____ Group Number_____

Address _____

City_____ ST_____Zip_____Phone____-_____

Over Please

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 and 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.

I understand that I am responsible for all costs of dental treatment, and understand that payment is due at the time the services are rendered. Any other financial arrangements must be approved by the financial coordinator prior to treatment. We will gladly process your insurance claims for reimbursement. You must realize that your insurance coverage is a contract between you, your employer, and the insurance company. We file the claims only as a courtesy to you; payments must be paid on your part during treatment. All unpaid accounts will be subject to a monthly service charge and/or 18% interest rate.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. Should my account go to collections, I agree to pay all court costs and reasonable attorneys fees plus a 40% collection fee that will be added to my account. 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.

A $25.00 fee will be charged on all returned checks. All appointments must be kept promptly. When cancelling, 24 hours notice must be given or a $47.00 charge will be made.

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 acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

X_____ _____ _____

Signature of Patient, parent or guardian Date Relationship to Patient

(Rev. 1/07)

Name: _____ Date of Birth: _____

Medical History

Physician's Name (medical) _____ Date of Last Visit _____

Have you had any serious illness or operations? ☐ Yes ☐ No

If yes, please describe _____

In case of emergency, who should be notified? _____ Phone _____ - _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check ☐ if you have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ HIV Positive	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ Jaw Pain	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Kidney Disease	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Mitral Valve Prolaps	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Glaucoma	☐ Nervous Problems	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Osteoporosis Treatments	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	☐ Hemophilia	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hepatitis	☐ Respiratory Disease	☐ Venereal Disease

Are you currently using any of the following? Or have you ever used previously?

Oral Bisphosphonates		IV Bisphosphonates	
Brand Name	Generic Name	Brand Name	Generic Name
_____ Fosamax	alendronate	_____ Aredia	pamidronate
_____ Fosamax Plus D	alendronate	_____ Zometa	zolendronic acid
_____ Actonel	risedronate	_____ Bonefos	clodronate
_____ Boniva	ibandronate	_____ Aredia	pamidronate
_____ Skelid	tiludronate		
_____ Didronel	etidronate		

Have you used any other drug prescribed to decrease the resorption of osteoporosis? _____

If yes, when and how long? _____

List medications you are currently taking:

_____

_____

_____

Medication Allergies:

_____

_____

_____

I have been made aware of the current information regarding my medication its potential risks and side effects.

_____ X_____ _____

Patient's name (please print) | Signature of patient, legal guardian or authorized representative | Date

_____ _____

Witness to signature | Date