My Family DENTIST

EDDIE S. FADDIS, D.D.S.
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SUITE 202
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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

Date_____ How were you referred to our office? _____

Name_____Social Sec. No. ____/____/____Birthdate____/____/____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Email: _____

Sex M F Marital Status M S W D

Your Employer_____Phone _____Occupation _____

Spouse_____ Social Sec. No. ____/____/____Birthdate____/____/____

Spouse's Employer_____Phone _____Occupation _____

Account Information/Insurance

Person Financially Responsible (if different than above)_____Relationship_____

Residence Address_____C/S/Z_____

Home Phone_____SSN_____

Employer_____ Work Phone_____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMAITON BELOW

DENTAL INSURANCE

Insured's Name_____SSN_____

Patient's Relationship to Insured Self_____ Spouse_____ Child_____Other_____

Employer_____ Phone_____

Dental Insurance_____

ID Number _____ Group Number_____

Address _____

SECONDARY INSURANCE

Insured's Name_____SSN_____

Patient's Relationship to Insured Self_____ Spouse_____ Child_____Other_____

Employer_____ Phone_____

Co Dental Insurance_____

ID Number _____ Group Number_____

Address _____

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. 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 18% per month* 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 the dentist, 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 have other financial arrangements in place. In the event my account becomes delinquent, I agree to pay the remaining balance and specifically agree to pay all reasonable attorney's fees and court costs in the event of legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

I hereby assign all dental benefits including private insurance and other health plans to Eddie Faddis DDS. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize said assignee to release all information and records necessary to secure the payment. To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of my medical records. 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 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 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.

This agreement supersedes all prior signed agreements, 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 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

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

Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? YES NO

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

Have you ever taken Fosamax, Boniva, Actonel or any other drugs prescribed to decrease the resorption of bone as in osteoporosis, or any drugs for metastaticbone cancer? YES NO

List medications you are currently taking:

_____
_____
_____
_____
_____

Medication Allergies:

_____
_____
_____
_____
_____

I hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical condition or in medications I take can affect dental treatment, I understand the importance of and agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

_____ X _____ _____

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

_____ _____

Witness to signature | Date