238 East State Rd #2
Pleasant Grove, UT 84062

485 South Main Street #302
Springville, UT 84663

Patient Registration Form

Patient Information:

Last Name	First Name	Middle Initial	Preferred Name
Street Address	City/State/Zip Code		Social Security #
Cell Phone	Date of Birth		Male or Female
Home Phone	Email		Marital Status S / M / D / W
Guardian Name (if patient is under age 18)			Guardian Date of Birth
Emergency Contact Name	Phone #		Relationship

Employer Information:

Name	Work Number
Address	City/State/Zip Code

Referred By:

Referred By:	Address	Phone #
Primary Care Physician:	Address	Phone #

Insurance Information:

Name of First Insurance Company		Subscriber	
Street Address	City	State	Zip Code
Insurance ID Number/Subscriber's SSN		Local/Group Number	
Name of Secondary Insurance Company		Subscriber	
Street Address	City	State	Zip Code
Insurance ID Number		Local/Group Number	

Subscriber Information: (Policyholder if different from patient)

Relationship to Patient	Name	Date of Birth
Social Security	Address	Zip Code
Home Number	Employer's Name	Work Number

Signature of Patient or Authorized Representative: **Date:**

Grove Creek DENTAL
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A PLACE TO SMILE
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Patient Name:_____ Patient Date of Birth:_____

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant? How many weeks along?_____ ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	Yes No	If yes

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

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:

X Date:_____

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Consent to Proceed

I authorize Dr. Jonathan Jackson 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 possible risks, including the risk of substantial and serious harm, if any, which may be associated with 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:**_____

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Financial Policy - Insurance

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide you with a variety of different payment options to help you receive the dental care you need and deserve and also that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstanding, we ask patients to accept and adhere to the following financial agreements regarding their dental treatment.

Insurance Billing:

Our office will submit claims to insurance companies for payment on dental treatment, however the patient agrees to the following terms:

1. It is the patient's responsibility to verify coverage. Our dental office is not responsible for knowing what services are covered by the patient's insurance plan and is not responsible for informing the patient whether a particular service is covered. We will assist the patient in obtaining payment from his/her insurance company by submitting the necessary insurance claims. Our office cannot guarantee payment for treatment from any insurance company, regardless of any pre-authorizations.

2. The full balance, including the estimated insurance portion, is the responsibility of the patient, and it is the office's discretion to collect up to the full amount at the time of service, or an estimated patient portion pending insurance payment. Our office does our best to estimate patient responsibility before treatment is performed, but the insurance payment may vary and the patient is responsible for any amount that the insurance company does not cover. Prices, fees, or benefits quoted in our office are estimates only. Final charges or benefits paid by the insurance company will be based on work performed and claims filed after work has been completed.

4. If an insurance company does not pay benefits within 60 days from our filing date the guarantor will become responsible for the full outstanding balance. If an insurance company pays benefits after that time the patient will be eligible for a refund of the balance of any personal payments made.

5. If an insurance company does not cover a procedure due to waiting periods, lack of coverage, frequency limitations, insurance maxing out, or any other reason, the office may charge their full usual and customary fees for those procedures.

6. It is the patient's responsibility to inform our office of any changes in insurance coverage. Our office is not notified of any insurance changes by the patient's insurance company or employer.

Sign:_____ **Date:**_____

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Financial Policy - Additional Terms

Optional Payment Terms:

1. Full Pay DOS Cash discount for Non Insured Patients: We offer a 5% accounting courtesy for all treatment for which your co-pay is paid in full (cash) at the time of service.
2. Major Service- Split payment options: We offer a split-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one half of your co-payment at the initial visit and the second payment at the seat date appointment.
3. Term Loan: By arrangement with Care Credit, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payments, no annual fee, and no prepayment penalty. Please ask for an application or log on to www.carecredit.com

Payments are expected at the time services are rendered:We accept cash, checks (under $500), debit cards and all major credit cards. Patients will be responsible for a $40 fee in addition to the previous balance if a payment is returned or a check bounces.

Collection Fee: Should collection become necessary, I hereby expressly agree to pay all costs of collection including an additional 40% whether or not the account is turned to an outside collection agency. I further agree to pay all court costs and attorney's fees should legal action become necessary.

Finance Charge: Interest will start accruing on unpaid balances at 90 days at a rate of 1.5% per month (18% annual) with a minimum charge of $2.00.

Broken Appointment Fees: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a $75 cancellation fee. Our office may waive that fee for emergencies at our discretion.

Sign:_____ **Date:**_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patients:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may render or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgement if you wish.

I Acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here_____

Signature_____

Date_____

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

( ) The patient refused to sign
( ) Due to an emergency situation, it was not possible to obtain acknowledgement
( ) We weren't able to communicate with the patient
( ) Other (Please provide specific details)

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Authorization to Release Copy of Dental Records

I, the undersigned, am over the age 18 and authorize **Grove Creek Dental** or **A Place To Smile** to release a copy of/information from my dental records to the following individuals who are also over age 18 (I.E. a spouse, parent, or significant other):

NAME:_____**PHONE**_____

RELATIONSHIP_____.

NAME:_____**PHONE**_____

RELATIONSHIP_____.

NAME:_____**PHONE**_____

RELATIONSHIP_____.

NAME:_____**PHONE**_____

RELATIONSHIP_____.

I understand that I may be charged a nominal fee for this service if paper records are required.

_____
Patient Name (Please Print Legibly)

_____
Signature

_____
Date