Imagine Family Dentistry

382 South Bluff Street, Suite #250 St. George, UT 84770 (435) 656-1111

Patient Information

Patient Name: _____ Date: _____
Last First MI Preferred

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married Birthdate: ____/____/____

Mailing Address: _____ SSN: _____-___-_____

_____
City State Zip

Phone: Home (___) _____-_____ Work (___) _____-_____ Cell (___) _____-_____

Email: _____@_____._____ May we send text reminders? ☐ Yes ☐ No

Employer Name: _____ May we call you on your cell phone? ☐ Yes ☐ No

Emergency Contact Name: _____ Relationship:_____

Phone Number: (___) ___-_____ Address: _____

Responsible Party Information

Name: _____ **Same as Above:** ☐
Last First MI Preferred

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married Birthdate: ____/____/____

Mailing Address: _____ SSN: _____-___-_____

_____
City State Zip

Phone: Home (___) _____-_____ Work (___) _____-_____ Cell (___) _____-_____

Employer Name: _____

Is the responsible party a patient of Imagine Family Dentistry? ☐ Yes ☐ No

Insurance Information-*all information refers to Insured Member*

Name: _____ Birthdate: ____/___/___

Mailing Address: _____ SSN: _____-___-_____

_____
City State Zip

Phone: Home (___) _____-_____ Work (___) _____-_____ Cell (___) _____-_____

Employer Name: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Is the insured a patient of Imagine Family Dentistry? ☐ Yes ☐ No

Insurance Company Name: _____

Insurance Company Phone Number: _____

How did you hear about our office? _____

Imagine Family Dentistry

Patient Name: _____ **Date:** _____

Signature on File

1. I authorize the use of this form on all my insurance submissions.
2. I authorize release of information to all my insurance carriers.
3. I understand that I am responsible for my bill, regardless of whether insurance pays or not.
4. I authorize my doctor to act as my agent in helping me to obtain payment from my insurance carriers. Any amounts not paid by insurance within 60 days of the service date will be paid by me.
5. I authorize payment directly to my doctor for services.
6. I permit a copy of this authorization to be used in place of the original.

Name: _____ Date: _____ Witness_____

(Please print)

Signature: _____

Consent for Treatment

1. I hereby authorize Dr. _____, and team members to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize _____ to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. 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.

4. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I agree to pay all costs of collection including a 33.3% collection fee, attorney fees, court costs and a finance charge (interest) at the rate of 1 ½% (18% APR) with a minimum charge of $5. If required, I also understand a check of my credit history may be made.

Patient's Signature: _____ Date: _____ Witness: _____

Parent/Responsible Party Signature: _____ Relationship: _____

Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
   If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes No
   If yes, please list name and dosage _____
5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice ..	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Cancer	Yes	No

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, etc.)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

Please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to replace your silver fillings?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Do you feel nervous about having dental treatment?	Yes	No
Please describe _____		
Have you ever had an upsetting dental experience?	Yes	No
Please describe _____		
Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe _____

_____

(Please complete other side)

Imagine Family Dentistry

Medical Information Form
(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination(s) rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call: ☐ My Home ☐ My Work ☐ My Cell Number _____

If unable to reach me:

☐ You may leave a detailed message
☐ Please leave a message asking me to return your call
☐ _____

The best time to reach me is: _____(day) between _____(Time)

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____