

# Provo Dental Care

NAME: \_\_\_\_\_ PREFERRED NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK # \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ WHO REFERRED YOU \_\_\_\_\_

DO YOU HAVE ANY FAMILY MEMBERS THAT ARE ALREADY PATIENTS? \_\_\_\_\_

EMERGENCY CONTACT PERSON: \_\_\_\_\_ PHONE # \_\_\_\_\_

PERSON RESPONSIBLE FOR THIS ACCOUNT:

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE # \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ ID # \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

MEDICAL HISTORY: PLEASE CIRCLE IF YOU HAVE A HISTORY OF THE FOLLOWING:

AIDS ASTHMA BACK PROBLEMS CANCER DIABETES EPILEPSY HEPATITIS HIV JAW PAIN

KIDNEY DISEASE RESPIRATORY DISEASE RHEUMATIC FEVER THYROID PROBLEMS

TOBACCO HABIT

IF ANY OF THESE WERE CIRCLED, PLEASE DESCRIBE \_\_\_\_\_

ARE YOU CURRENTLY PREGNANT? YES \_\_\_ NO \_\_\_

HEART CONDITIONS: PLEASE DESCRIBE \_\_\_\_\_

ARTIFICIAL JOINTS: PLEASE DESCRIBE \_\_\_\_\_

PLEASE LIST OTHER CONDITIONS NOT LISTED: \_\_\_\_\_

PLEASE LIST MEDICATIONS YOU ARE TAKING: \_\_\_\_\_

PLEASE LIST ANY ALLERGIES YOU HAVE: \_\_\_\_\_

HIPAA: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I \_\_\_\_\_ DATE \_\_\_\_\_ HAVE RECEIVED A COPY OF PROVO DENTAL CARE'S PRIVACY PRACTICES.

AUTHORIZATION

I CERTIFY THAT I HAVE READ AND ACCURATELY ANSWERED THE ABOVE QUESTIONS. I UNDERSTAND THAT INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAM RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST. I UNDERSTAND MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF FOR MY DEPENDENTS.

SIGNATURE OF PATIENT OR GUARDIAN X \_\_\_\_\_ DATE \_\_\_\_\_