



Welcome

Thank you for selecting Alta View Dental Care!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Patient's Sex F M
Address _____ City _____ Home Phone _____
State/Prov. _____ Zip/PC. _____
Email _____ Cell Phone _____

Do you prefer to receive calls at your: Home Work Cell Phone
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/PC. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/PC. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/PC. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/PC. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/PC. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Patient Medical History



Physician _____ Office Phone _____ Date of Last Exam _____

- | | |
|--|---|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you have or have you had any of the following?</p> | <p>10. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Are you allergic to or have you had any reactions to the following?</p> <p>Local Anesthetics (e.g. Novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p> <p>12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

- | | | |
|--|---|---|
| <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever / Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p> |
|--|---|---|

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | |
|---|---|
| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following problems in your jaw?</p> <p>Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|---|

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____ Date _____
Signature of patient (or parent/guardian if minor)

Alta View Dental Care & Headache Relief Center

Alta View Dental Policies

Dental Benefit Policy:

Alta View Dental will submit claims to your dental insurance as a courtesy to you. It is understood that, ultimately, you are financially responsible for all dental treatment completed, and any amount your benefits do not cover. We will do all we can to facilitate payment of claims; however, it is understood that it is your responsibility to know your benefit plan, and realize that it is a contract between your employer, the benefit provider, and yourself. After two billing attempts to your benefit provider, it is your responsibility to pay your account balance.

Payment Policy:

Alta View Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. For plans requiring multiple appointments, alternative payment arrangements may be provided. **Alta View Dental charges \$40 fee for returned checks.**

It is understood that if the entire balance on your account is not paid within 14 days of the monthly billing date, a billing charge will be added, at the rate of 18%. In the case of default of payment, you are responsible to pay any legal interests, collection costs (equal to 40% of the outstanding balance), and reasonable attorney fees incurred to collect on your account

Late/Cancellation:

At Alta View Dental, we value your time. To ensure that all patients receive quality care, we ask that you arrive to all appointments 15 min prior to the scheduled appointment time. This allows us the necessary time to review your health history, any benefit information and to collect your payment. If you arrive late, we may need to alter treatment for that appointment. If you arrive more than 15 minutes late, we may not be able to attend to you that day, and you will need to reschedule your appointment. We are committed to excellence; this includes maintaining on-time appointments. If you must cancel your appointed treatment time, please extend the courtesy of a 48-hour notice. **In some cases, a \$25 missed appointment fee may be added to your account if less than 48-hour notice is given.**

Patient Name (Print): _____

Patient Signature: _____

Relationship to Patient: _____

Alta View Dental Care
Inspiring Focused Results

Notice of Privacy Practices Acknowledgement

I Understand that, under the health insurance portability & Accountability act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to.

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payer.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Alta View Dental Care
9844 South 1300 East, Suite 340
Sandy, UT 84094

I acknowledge that I have received the notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of privacy practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the notice of private practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Patient Signature: _____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:

Initials:

Reason: