Utah Periodontal Specialists
Health Questionnaire

Date _____

Patient Name: _____ Male ____ Female ____

Preferred Name_____ Birthdate: _____/_____/_____

Marital Status: Married _____ Single_____ Child _____ Guardian (*If Minor*) _____

Guardian DOB_____/_____/_____ Email_____

Address: _____

Phone number(s) Home: _____ Work: _____ Cell: _____

Employer: _____Occupation: _____

Employer's Address: _____

Emergency Contact: _____Relationship: _____ Phone Number: _____

Whom may we thank for referring you? _____

Who is your Dentist? _____Location _____

Are you currently under the care of a physician for a medical condition? YES___ NO___

Physician: _____ Phone: _____

Address: _____

Please check if you have a history of any of the following:

Yes	No		Yes	No	
		High Blood Pressure /Hypertension			Anemia
		Heart Murmur			Bleeding disorder
		Rheumatic Fever			Kidney Disease
		Mitral valve prolapse			Renal Dialysis
		Angina / Chest pain			Organ transplant
		Heart Attack			Cancer
		Prosthetic (artificial) heart valve			Radiation Therapy
		Irregular / rapid heart beat			Chemotherapy
		Pacemaker			Epilepsy/Seizures
		Heart disease			Stomach Ulcer
		Heart or bypass surgery			Colitis / Intestinal problems
		Stroke			Arthritis
		Sleep Apnea			Artificial joints
		Asthma / Lung Disease			Sexually transmitted disease
		Diabetes			AIDS/HIV
		Thyroid Disease			Tuberculosis (TB)
		Liver disease / Hepatitis / Jaundice			Psychiatric Treatment

Please list any other medical problems not listed above: _____

ALLERGIES OR ADVERSE REACTIONS: (Please circle all that apply.)

Penicillin Sulfa drugs Latex Local Anesthetics Aspirin

Codeine / Narcotics Iodine Barbiturates Sedatives Sleeping Pills

Other _____

Please list **ALL** of the medications you are currently using including over-the-counter medications, vitamins, herbal supplements, ointments and eye drops:

Medication	Dose	How often?

Have you taken an appetite suppressant (such as Fen-Phen)? YES NO

Have you taken osteoporosis bisphosphonates or alendronates like Fosamax, Boniva, Reclast or Acotnel? YES NO

If yes, for how long have you taken it? _____

Please list all hospitalizations and surgeries:

_____ Date _____

_____ Date _____

_____ Date _____

Do you have a history of using tobacco? YES NO

Do you use alcohol? YES NO

If yes, how much? _____

Dental History:

Have you ever had orthodontics (Braces)? YES NO When _____

Have you had your wisdom teeth removed? YES NO When_____

Have you experienced bleeding gums? YES NO

How often do you have professional dental cleanings? _____

How many times a day do you brush your teeth? _____

Manual_____ Electric_____ How often do you floss? _____

Review of Systems:

Have any wounds healed slowly or presented other complications? YES NO

Do you have persistent swollen glands in your neck? YES NO

Have you ever had abnormal bleeding, bruising or required a blood transfusion? YES NO

Have you had persistent diarrhea or recent unintentional weight loss? YES NO

Do you habitually clench or grind your teeth during the night or day? YES NO

Do you have jaw joint problems such as clicking, locking or pain? YES NO

What types of diseases, cancer or dental problems run in your family? _____

_____

Are there any other medical or dental conditions we should know about before rendering treatment?

If so, explain: _____

For women only:

Are you pregnant? YES NO

Are you nursing? YES NO

Are you taking birth control pills? YES NO

Note: Antibiotics may decrease the effectiveness of your birth control

VERIFICATION: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical conditions or medications can effect my dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment. I authorize Drs. Knight, Nielsen, and Skene and/or such associates or assistants as they 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.

Signature _____ _____

Patient or Guardian Relationship

Utah Periodontal Specialists
Financial Questionnaire

Date _____

Person Responsible for Account

Name _____
Last First

Relationship to patient _____Birthdate _____/_____/_____

Phone number(s) Home: _____Work: _____ Cell: _____

Billing Address _____

Employer:_____

Dental Insurance

Primary Dental Insurance

Insurance Company Name _____

Insurance Company Address _____

_____

Insurance Company Phone _____

Subscriber ID# _____ SS# (If applicable)_____

Subscribers Name _____ Relationship to patient _____

Subscriber's Birthdate _____/_____/_____

Employer _____

Secondary Dental Insurance

Insurance Company Name _____

Insurance Company Address _____

_____

Insurance Company Phone _____

Subscriber ID # _____

Subscriber's Name _____ Relationship to patient _____

Subscriber's Birthdate_____/_____/_____ SS# (If applicable)_____

Employer _____

Parent/Spouse Information

Name _____
Last First

Birth-date _____/_____/_____ SS# _____ DL# _____

Phone number(s) Home: _____Work: _____ Cell: _____

Employer _____

AGREEMENT TO PAY / FINANCIAL ACKNOWLDEDGEMENT

Please be prepared to pay your **estimated portion** at the time of service regardless of insurance coverage.
Please be prepared to show evidence of insurance coverage (if applicable) and Picture ID at all appointments.

1. Professional services are rendered to the patient, and not the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

2. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.

3. **For your convenience we will ESTIMATE the portion of your total fee that your insurance company will cover. This is JUST AN ESTIMATE. After insurance benefits, you are responsible for ANY UNPAID BALANCE. We will ask you to bring with you at the time of surgery the ESTIMATED uncovered portion of the total fee.**

4. A finance charge of 1-1/2% per month will be added your bill if payment has not been received within 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.

5. Should collection become necessary, the responsible party agrees to pay additional collection fees, returned check fees, and all legal fees of collection, with or without suit, including attorney fees and court costs. I also authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. **I hereby authorize release of information for insurance purposes.**

Thank you for your understanding in this matter.

Signature: _____ Date: _____
(Patient, Legal Guardian or Authorized Agent of Patient)

Witness: _____ Date: _____

Utah Periodontal Specialists Inc
HIPAA RELEASE & CANCELLATION POLICY

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

Guardian Giving Consent:_____ Relationship_____

HIPPA RELEASE OF INFORMATION

Purpose of the consent: By signing this HIPPA release, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations to the recipients detailed below.

Indicate the following that apply:
☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information to my referring doctor and insurance company.

This information may also 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. I understand that I may request a copy of the Privacy Policy and that this authorization is valid for the period of time needed to fulfill its purpose.

Signature: _____ Date: ____/____/_____

CANCELLATION POLICY

In consideration for our patients, the cancellation/missed appointment policy is as follows:

Please note that any appointment cancelled or missed without a **24 hour notice** by phone call will be assessed a minimum of a **$50.00 fee**. Cancellation by email or text does **NOT** qualify as an acceptable form of notification.

Signature: _____ Date: ____/____/_____