SALTWATER DENTAL

Dillon Jensen D.D.S.
(801) 485-2627

Patient Registration

Welcome

Patient Information

Today's Date: ______________________ Birth Date: ______________

Name: ______________________ SS#: ______________
Last First Mi

Address: ______________________ Sex: M / F
Street Apt.

Address: ______________________ Marital Status: ______________
City State Zip Code

Home Phone: (   ) __________ Work Phone: (   ) __________ Cell Phone: (   ) __________

Email: ______________________

Employer: ______________ Employer Address: ______________________

Emergency Contact: ______________________ Phone: (   ) __________
Name Relationship

Whom may we thank for referring you? ______________________

Circle the best to confirm appointments: Home Work Cell Email

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Account Information

Person responsible for this account: ______________________

Billing address (if different from above): ______________________

Insured Person's Name: ______________________ SS#: ______________

Employer: ______________________ Phone: (   ) __________

Insurance Company: ______________________ Phone: (   ) __________

Insurance Company Address: ______________________
Street City State Zip

Group #: ______________ Policy #: ______________ Plan: ______________

Confidential

Dental Health History

Name: ______________________ Today's Date: ____________
Last First Mi

Reason for today's visit: ____________ Former Dentist: ____________

Date of last dental care: ____________ Date of last dental x-rays: ____________

Are you interested in bleaching your teeth? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Have you had problems with any of the following?

☐ Bad Breath ☐ Grinding Teeth ☐ Sensitivity to hot or cold
☐ Bleeding Gums ☐ Loose Teeth ☐ Broken Fillings
☐ Sensitivity to Sweets ☐ Clicking or Popping Jaw ☐ Periodontal Treatment
☐ Sensitivity to Biting ☐ Food Collection Between Teeth ☐ Sores or Growths in your mouth

How often do you brush? ____________ How often do you floss? ____________

Medical History

Physician's Name: ____________ Phone: ( ) ____________

Have you had any serious illnesses/operations? ☐ Yes ☐ No If yes, describe: ____________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approx. date: ____________

(Women)
Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Check any that apply to you:

☐ Anemia ☐ Cortisone Treatments ☐ High Blood Pressure ☐ Shortness of Breath
☐ Arthritis/Rheumatism ☐ Cough, Persistent ☐ HIV/AIDS ☐ Skin Rash
☐ Artificial Heart Valve ☐ Diabetes ☐ Jaw Pain ☐ Stroke
☐ Artificial Joints ☐ Epilepsy ☐ Kidney Disease ☐ Swelling
☐ Asthma ☐ Fainting ☐ Liver Disease ☐ Thyroid Problems
☐ Back Problems ☐ Glaucoma ☐ Mitral Valve Prolapse ☐ Tobacco Habit
☐ Blood Disease ☐ Headaches ☐ Pacemaker ☐ Tonsillitis
☐ Cancer ☐ Heart Murmur ☐ Radiation Treatment ☐ Tuberculosis
☐ Chemical Dependency ☐ Heart Problems ☐ Respiratory Disease ☐ Ulcer
☐ Chemotherapy ☐ Hemophilia ☐ Rheumatic Fever ☐ Venereal Disease
☐ Circulatory Problems ☐ Hepatitis ☐ Scarlet Fever

Allergies
☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sleeping Pills ☐ Sulfa ☐ Other: ____________

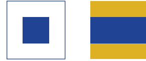
List of current medications: ____________

Pharmacy Name: ____________ Phone: ( ) ____________

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Jensen or any of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____________ Date: ____________

SALTWATER DENTAL



I agree to pay for all services provided to me or to members of my family by Saltwater Dental. I understand that Saltwater Dental will, as an accommodation to me, seek payment from my insurance company for amounts covered by insurance. I understand, however, that ***IF MY INSURANCE PROVIDER DOES NOT PAY*** for the dental service, I am ultimately responsibly to pay all amounts owing in full within 90 days from the date of service unless Saltwater Dental has agreed to other payment arrangements.

If I fail to pay the balance owed in full when due, I agree I will be responsible for interest at the rate of 18% annually, calculated from the date of service. If my account is sent to collections, I agree that in addition to any amount left owing to Saltwater Dental, I will be responsible for a collection fee, court costs, and responsible attorney's fees, with or without suit, incurred in collecting any past due balance.

I understand that I will be charged a fee of $50 if I cancel a scheduled appointment with Saltwater Dental within twenty-four hours of the appointment. I understand further that, due to office policy and certain insurance contracts, appointment cancellation fees are not negotiable and will not be removed from my statements. I also understand that Saltwater Dental does not accept any cancellations by voicemail.

I authorize Saltwater Dental to obtain a consumer credit report in connection with the credit extended on my account. If there is any conflict between the terms and this Agreement and the patient-intake forms, the terms of this Agreement supersede the patient-intake forms.

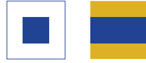
____________________________ ____________________

Print Name Date

____

Signature

SALTWATER DENTAL



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You may refuse to sign this acknowledgement.

I, ____________________, have received a copy of this office's Notice of Privacy Practices.

Print Name ____________________ Date ____________________

Signature ____________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual Refused to Sign
☐ Communication barriers prohibited obtaining the acknolwdgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify): ____________________