Date: _____

newparkdentistry

Dr. Jon Coleman, DDS 1441 W. Ute Blvd, Ste 200 Park City, UT 84098

Patient Information:

Name:_____Date of Birth: _____ ◯ Male ◯ Female

Mailing Address:_____City:_____State:_____Zip:_____

Cell Phone:_____ Work Phone: _____

SSN:_____Email:_____

Who may we contact in case of emergency?_____

Emergency Contact Phone:_____Relationship:_____

Responsible Party Information: *(if patient is a minor)*

Name:_____Relationship:_____Date of Birth:_____

Address:_____Phone:_____

Employer:_____SSN:_____

Dental Insurance Information:

Primary Insurance Company:_____Policy Holder Name:_____

Is the policy through: ◯ Self ◯ Employer: _____

Ins. Address:_____Phone:_____ID#:_____

Policy Holder SSN:_____Policy Holder DOB:_____

Secondary Insurance Company:_____Policy Holder Name:_____

Is the policy through: ◯ Self ◯ Employer: _____

Ins. Address:_____Phone:_____ID#:_____

Policy Holder SSN:_____Policy Holder DOB:_____

**Who may we thank for referring you to our office?_____

Authorization:

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Jon Coleman or his agent. I grant the right to Dr. Coleman or his agent to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Patient Signature *(or parent/guardian)*: _____

HIPAA Consent Form

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, but is not mandatory for me to sign in order 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 payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. 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 Privacy 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 that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____Relationship to Patient:_____

Patient Signature (parent/guardian):_____Date:_____

Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date:_____

Dental History

Patient Name:_____

Former Dentist:_____City/State:_____

Why did you leave that dentist?_____

When was your last dental cleaning?_____

Were x-rays taken? ◯ Full Mouth Set ◯ Panoramic ◯ Other ◯ No X-rays Taken

Have you ever been treated for gum disease (periodontal disease)? ◯ Yes ◯ No

If so, what treatment did you receive?_____

Are your teeth sensitive to: ◯ Nothing ◯ Sweet ◯ Cold ◯ Heat ◯ Pressure

Have you had your wisdom teeth removed? ◯ Yes ◯ No ◯ Other:_____

Please rate the appearance of your smile: *Poor* 1 2 3 4 5 6 7 8 9 10 *Excellent*

Have you ever had your teeth straightened/worn braces?	◯ Yes ◯ No
Would you like straighter teeth?	◯ Yes ◯ No
Would you like a whiter smile?	◯ Yes ◯ No
Are you concerned with bad breath?	◯ Yes ◯ No
Do you snore or have sleep apnea?	◯ Yes ◯ No
Are you aware of possible TMJ problems? *(Does your jaw pop, lock, or have pain?)*	◯ Yes ◯ No
Do you clench or grind your teeth?	◯ Yes ◯ No
Do you wear a night guard/bite guard?	◯ Yes ◯ No

Is there anything else that would be valuable for us to know so we can best care for you?

_____

_____

Newpark Dentistry, P.C. Financial Agreement

Just as we are committed to providing excellent dental care, we are concerned with making it affordable to you. It is important to us that you are aware of your options regarding your financial policy. We do offer payment plans for patients who want to complete comprehensive care. The patient must decide for themselves as to whether they want the best.

To help our office serve you efficiently, we ask that you take a moment to review the choices below and determine which would be best for your needs.

1. Full payment on the day of service without insurance; we accept cash, check, debit and credit card payments.
2. We also offer outside financing, which is an extended payment plan through Care Credit. (Subject to approval) They offer 13.9% APR and 12-month interest free if charges exceed $300. Please ask for an application if you are interested.

Dental Insurance: Our practice was recently refined to reflect the problems associated with insurance or dental marketing companies not paying the dental bill in a timely fashion. The traditional relationship exists between the patient and their benefit plan. The dental office is a 3rd party to this relationship and over time has been viewed as a banking entity. As with most service-oriented businesses, we request payment at the time of treatment for the portion of service not covered by insurance. This can range from 0-100% depending on your insurance policy. Many insurance companies reimburse professional fees on a complicated fee averaging basis. Your insurance company will show average fees from a wide geographic area. They fail to take into consideration location, training, and experience of your doctor. This system may or may not be representative of fees in the Park City area. Because of this, our fees may be above or below the "usual and customary" fee provided to you by your insurance company. This may influence the co-pay amount you will be obligated to pay. This sounds confusing because it is. **As a courtesy to our patients we will submit your dental claims; however, if the insurance company has not paid their estimated portion within 60 days, the patient is responsible for the full balance.**

Fee for failure to cancel: I/We agree that the reasonable fee may be assessed for any appointments which are missed or broken without 24-hour prior notice of cancellation. I also understand that failure to pay this fee may result in collection proceedings.

Promissory Note: I/We agree that the responsibility for payment of services in this office, for myself or for my dependents are joint and several, due and payable at the time services are rendered or as outlined in other arrangements. I /We agree to make all payments when due. I/We further understand that a monthly finance charge of 1.5% shall apply to any balance over 90 days. In the event of breach of this agreement or failure to pay for services as set forth in this agreement, I/We jointly and severally agree to pay the principal balance due, all accrued interest at the contract rate of 18% APR from the date the services were rendered, together with all the costs of collection, including attorney's fees incurred, whether or not the matter proceeds to collection, litigation or final judgment.

Signed By: Print Name: Date:

Consent to Proceed

I authorize Dr. Coleman and/or such associates or assistants as s/he 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, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ **Date:** _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ **Date:** _____

(Rev. 11/16)