How Did You Hear About us? Radio__Print Ad__________Fam or Friend__Dentist___
Billboard__Sign__Yellow Pgs__Ins Co___Printed Material(where)____________________

Parkway Dental
48 S. Main, Helper, UT 84526

Have immediate family members been seen in our office? ___Yes ___No
If so, what are their names____

____

Please fill in as completely as possible - all highlighted areas required TODAY's DATE:______________

Patient Personal Information

Title____________Nickname____________________Birth Date_____________Age__________Sex_______SSN______________

Last, First____ Marital Status________________ Home #______________

Address (Mailing) ____ Work# _______________ Cell #____________________

City, State, Zip ____ Email ______________________________________

Person responsible / guarantor for paying bills

Title____________Nickname____________________Birth Date_____________Age__________Sex_______SSN______________

Last, First____ Marital Status________________ Home #______________

Address (Mailing) ____ Work# _______________ Cell #____________________

City, State, Zip ____ Email ______________________________________

Do you have Primary Dental Insurance? _____Yes _____No Do you have Secondary Dental Insurance? ____Yes ___No

Primary	Secondary
Group No / Name____________________	Group No / Name____________________
Insurance Name____________________	Insurance Name____________________
Employer Name____________________	**Employer Name**____________________
Subscriber Last, First____________________	Subscriber Last, First____________________
Subscriber Address____________________	Subscriber Address____________________
City, State, Zip____________________	City, State, Zip____________________
Relationship to Patient__________Birth Date__________	Relationship to Patient__________Birth Date__________
Subscriber ID____________________	Subscriber ID____________________

Patient Medical Information

☐ **No Known Allergies**

Allergic To
☐ Aspirin
☐ Barbiturates / Sleeping Pills
☐ Codeine
☐ Erythromycin
☐ Iodine
☐ Latex Rubber
☐ Local Anesthetics
☐ Metals
☐ Epinephrine
☐ Penicillin
☐ Prior Hepatitis
☐ Sulfa Drugs
☐ Other Narcotics

Check, if applicable
☐ No Change Since Last Recorded
☐ **No Known Concerns or Issues**
☐ AIDS / HIV Infection
☐ Alcohol / Drug Abuse
☐ Anorexia / Bulimia
☐ Anemia / Leukemia
☐ Ankles Swell
☐ Arthritis
☐ Asthma / Hay Fever
☐ Blood Clotting Problems
☐ Blood Transfusion
☐ Bronchitis
☐ Cancer / Tumor or Growth
☐ Cardiac Pacemaker
☐ Chest Pain Upon Exertion
☐ Contact Lenses
☐ Damaged Heart Valve
☐ Diabetes
☐ Emphysema
☐ Environmental allergies
☐ Epilepsy
☐ Fainting Spells / Seizures
☐ Fever Blisters / Herpes
☐ Joint Replacement
☐ Frequent Headaches
☐ Frequent Dry Mouth / Sjogren
☐ Gag Reflex
☐ Gall Bladder Trouble
☐ Heart Attack / Stroke
☐ Heart Disease / Angina
☐ Heart Murmur
☐ Hepatitis / Jaundice
☐ High Blood Pressure
☐ Hives / Skin Rash
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Health Problems
☐ Mitral Valve Prolapse
☐ Pre-medicate
☐ Rheumatic Fever
☐ Rheumatic Heart Disease
☐ Kidney / Bladder Trouble
☐ Sexually Transm Disease
☐ Shortness of Breath
☐ Sinus Trouble
☐ Stomach Ulcers
☐ Thyroid Problems
☐ Tuberculosis
☐ Urinate frequently
☐ Unusual Weight Loss

Other
☐ See Dental Questionnaire
☐ See Medical Questionnaire
☐ See Scanned Documents: Pt.Notes

Dental Questionnaire

Date of your last cleaning & exam ______________________________

Do you chew / smoke tobacco in any form? ___Yes ___ No ______________________

Have you had any head, neck or jaw injuries? ___ Yes ___ No ______________________

Do you clench or grind your teeth? ___ Yes ___ No ______________________

Do you wear dentures or partials? If yes, date of placement? ___ Yes ___ No ______________________

Are you having any specific problems with your teeth, gums, or mouth at this time? ___ Yes ___ No ______________________

Do you have problems with teeth / fillings breaking? ___ Yes ___ No ______________________

Do you have an unpleasant taste or odor in your teeth / mouth? ___ Yes ___ No ______________________

Additional Comments ____

Medical Questionnaire

Family Physician ______________________ Phone ______________________

Are you currently under care of a Physician? ___ Yes ___ No ______________________

If, Yes, what is the condition being treated? ______________________

Have you had any serious illness, operation or been hospitalized within the past 5 years? ___ Yes ___ No ______________________

If Yes, what illness or problem? ______________________

Are you currently taking any medication? ___ Yes ___ No. If yes, what? ______________________

____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) ___ Yes ___ No ______________________

Have you ever taken the diet control drug Fen-Phen? ___ Yes ___ No ______________________

Do you smoke? Yes No

Women Only

Are you pregnant? ___ Yes ___ No ______________________

If Yes, what is your due date? ______________________

Are you currently nursing? ___ Yes ___ No ______________________

Additional Comments

Any Disease, Condition or Problem not Listed? Please list ______________________

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient / Guardian Signature **Date**

Consent for Services and Payment Agreement

I understand and agree that payment in full must be made at the time dental services are received unless a payment arrangement has been made prior to treatment. As a courtesy, Parkway Dental shall assist me in the preparation and submission of my dental insurance claims, but I understand that I am personally responsible for payment.

I agree to the value for the services provided, unless I object to the same when the services are provided or within thirty (30) days of receiving the services if a payment agreement is in effect. I agree that a waiver of any condition of payment shall not constitute a waiver of any other or future condition.

I understand, and by signing below, acknowledge, that I am financially responsible to pay for the goods and/or services provided to me by Parkway Dental. If payment is not made at the time of service, or as otherwise agreed, I agree to pay any and all additional collection agency fees and/or commissions, which might be as much as 40% of the principal balance due, as well as attorney fees and court costs. Parkway Dental or its assignee has my permission to telephone me at my residence or place of employment to discuss matters pertaining to my account.

Financial Policy

Please be advised that payment is due at the time of service. As methods of payment, we accept cash, personal checks, or major credit cards (Mastercard, Visa, Discover, or American Express). If you are covered by insurance, Parkway Dental will gladly bill your insurance company as a courtesy. The amount you are responsible for at the time of service is just an estimate. If the insurance company fails to pay that portion, then you are responsible for the remaining balance. You are responsible for consulting with your insurance company to verify your coverage and what allowances and restrictions are contained in your plan.

Missed Appointment Policy

When an appointment is scheduled, we commit a time slot to provide you with quality service. Parkway Dental needs 24 hours notice for cancellations of any appointment. If you miss your appointment without providing 24 hours notice, a missed appointment fee of $50.00 will be charged to your account. Payment of this fee will be required before the office can provide further service. Also, should you arrive late, you risk forfeiture of your appointment and will be assessed a fee.

I have read and understand the Consent for Services and Payment Agreement, Financial Policy, and Missed Appointment Policy of Parkway Dental. I have read the above conditions of treatment and payment and agree to their content.

Signature:____ Date:___________________

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: ______________________________ Date of Birth: ______________

Section B: To the Patient

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your health information.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices any time by contacting:

Contact Person: Eric Hall, Office Manager
Telephone: 435-201-6940 Fax: 435-472-1509
Address: 48 South Main, Helper, UT, 84526

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the consent person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you if you revoke this consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ Date: ________________

You are entitled to a copy of this consent after you sign it.