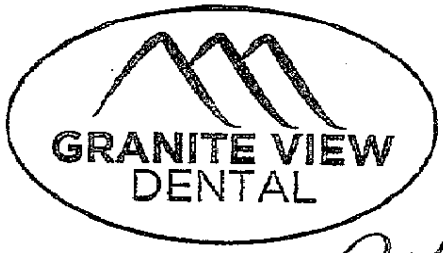


Dr. Will Ellingson, DMD
850 E 9400 S, Ste 100
Sandy, Utah 84094
801-255-2100

Welcome to our office!

PATIENT INFORMATION

Name: _____ (Last / First / Middle) Preferred Name: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SSN: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ (Street / City / State / Zip)

Home Phone: _____ Cell Phone: _____ Email: _____

When are the best times to reach you: _____ Driver's License # _____

Other family members seen by us: _____ Who can we thank for referring you? _____

Employer: _____

Employer Address: _____ (Street / City / State / Zip)

Emergency Contact Name: _____ Relation: _____ Work Phone: _____

Home Phone: _____ Address: _____ (Street / City / State / Zip)

SPOUSE INFORMATION

His/Her Name: _____

Birthdate: ___/___/___ SSN: _____

Employer: _____

Work Phone: _____ Ext. _____

Driver's License Number: _____

RESPONSIBLE PARTY FOR ACCOUNT

Name: _____ Relation: _____

Address: _____ (Street / City / State / Zip)

Home Phone: _____ SSN: _____

Employer: _____

Work Phone: _____ Ext. _____

Driver's License Number: _____

PRIMARY INSURANCE

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name _____ Phone: _____ Group # (Plan, Local or Policy #) _____

Insurance Address: _____ (Street / City / State / Zip)

Insured Name: _____ Insured SSN: _____ Insured Birthdate: ___/___/___ Relation: _____

Insured Employer: _____ Employer's Address: _____ (Street / City / State / Zip)

SECONDARY INSURANCE

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name _____ Phone: _____ Group # (Plan, Local or Policy #) _____

Insurance Address: _____ (Street / City / State / Zip)

Insured Name: _____ Insured SSN: _____ Insured Birthdate: ___/___/___ Relation: _____

Insured Employer: _____ Employer's Address: _____ (Street / City / State / Zip)

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Have you experience problems associated with any previous dental work? ☐ Yes ☐ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Your current dental benefit is ☐ Good ☐ Fair ☐ Poor
Do you floss daily? ☐ Yes ☐ No Brush Daily? ☐ Yes ☐ No
Type of bristle on your toothbrush? ☐ Soft ☐ Medium ☐ Hard
How long do you use a toothbrush before replacing it? _____
Do you use anything in addition to your brush and floss? ☐ Yes ☐ No
If yes, what? _____
Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No
Do you have mobility in your teeth? ☐ Yes ☐ No
Are your teeth sensitive to heat, cold or anything else? ☐ Yes ☐ No
Do you still have wisdom teeth? ☐ Yes ☐ No
If yes, why? _____

_____

Previous/Present Dentist: _____ Last Visit: _____
Why did you leave your previous dentist? _____
What did you like most & least about any dentist you have seen? _____

_____

_____

Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change? _____

_____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name _____
Address: _____
Phone #: _____ Date of Last Visit: _____
Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: _____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromyacin	Y N	Sedatives
Y N	Barbiturates	Y N	Jewelry/Metals	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Other

Please list additional drugs/materials for cause allergic reactions: _____

_____

For Women only: Are you taking birth control pills? Y N
Are you pregnant? ☐ Unsure ☐ Yes ☐ No
Week #: _____ Are you nursing? ☐ Yes ☐ No

Are you taking any of the following?

Y N	Acetaminophen	Y N	Blood Thinners	Y N	Insulin/Diabetes Drugs	Y N	Thyroid Medicine
Y N	Antibiotics	Y N	Blood Pressure Medication	Y N	Nitroglycerin	Y N	Tranquilizers
Y N	Antihistamines	Y N	Cold Remedies	Y N	Recreational Drugs		Have you ever taken Phen-Fen? Also know as Redux or Pondimin. ☐ Yes ☐ No
Y N	Aspirin	Y N	Digitals/Heart Medication	Y N	Steroids/Cortisone		

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins, or minerals not listed above? ☐ Yes ☐ No
If yes, please list each one: _____

_____

Do you or have you experience the following?

Y N	Abnormal Bleeding	Y N	Colitis	Y N	Headaches	Y N	Liver Disease	Y N	Shingles
Y N	Alcohol Abuse	Y N	Congenital Heart Defect	Y N	Heart Attack	Y N	Low Blood Pressure	Y N	Sickle Cell Disease
Y N	Anemia	Y N	Diabetes	Y N	Heart Murmur	Y N	Lupus	Y N	Sinus Problems
Y N	Arthritis	Y N	Difficulty Breathing	Y N	Heart Surgery	Y N	Mitral Valve Prolapse	Y N	Steroid Therapy
Y N	Artificial Bones/Joints	Y N	Drug Abuse	Y N	Hemophilia	Y N	Pacemaker	Y N	Stroke
Y N	Artificial Valves	Y N	Emphysema	Y N	Hepatitis	Y N	Persistent Cough	Y N	Thyroid Problems
Y N	Asthma	Y N	Epilepsy	Y N	Herpes	Y N	Psychiatric Problems	Y N	Tonsillitis
Y N	Blood Transfusion	Y N	Fainting Spells	Y N	High Blood Pressure	Y N	Radiation Treatment	Y N	Tuberculosis (TB)
Y N	Cancer	Y N	Fever Blisters	Y N	HIV+/AIDS	Y N	Rheumatic Fever	Y N	Ulcers
Y N	Chemotherapy	Y N	Glaucoma	Y N	Hospitalized for Any Reason	Y N	Scarlet Fever	Y N	Venereal Disease
Y N	Chicken Pox	Y N	Hay Fever	Y N	Kidney Problems	Y N	Seizures		

Please list any serious medical condition(s) that you have experienced: _____

_____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services I may need. My method of payment will be _____.

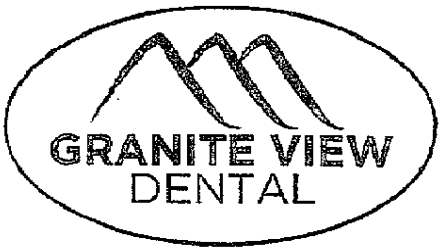
_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Will Ellingson all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date



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Consent to Proceed

I authorize Dr. William Ellingson D.M.D. and or such associates or assistants as 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, and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic or surgical treatments.

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medication can affect dental treatment, I understand the important of an agree to notify the dentist of any changes at any subsequent appointment.

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 rarly, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as a part of the dental tratment, including preventative procedures such as cleanings, and basic dentistry including fillings of all types, teeth may be sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. 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 aspired (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 do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative 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:** _____

GRANITE VIEW DENTAL

Dr. Will Ellingson, DMD
850 E 9400 S, Ste 100
Sandy, Utah 84094
801-255-2100

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of **Granite View Dental.**

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us (801) 255-2100.

I acknowledge receipt of the Notice of Privacy Practices of **Granite View Dental.**

Patient's Name: _____

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

Witness: _____ Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

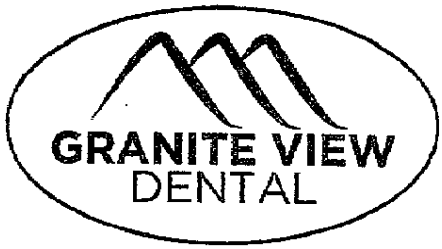
Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient's Name: _____

Reasons why the acknowledgment was not obtained:

- ☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- ☐ Other: _____

Signature of provider representative: _____ Date: _____



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Financial Policy

Thank you for selecting us as your dental health care provider. The following information describes our Financial Policy.

Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask.

Payment is due at the time of services are rendered. This includes non-covered fees and co-pays, unless payment arrangements have been approved by prior to the day of your appointment.

- We accept cash, checks, MasterCard, Visa, Discover, American Express, & Care Credit.
- A bill becomes delinquent after 60 days of no activity.
- A $25 fee will be charged on all returned checks.
- Patients who do not cancel their scheduled appointments within 24 hours prior to the scheduled time, will be charged a fee of $50.

NOTE: Insurance is a contract between you and your employer. Please contact them if you have questions regarding non-payment or coverage.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING

1. I agree that I am responsible for this debt regardless of my insurance and that I will pay any unpaid balance in full within 60 days of the date of service. I also agree to pay 18.5% interest per annum on the unpaid balance.
2. In the event that my account is not paid as agreed, I agree to pay a collection agency fee up to 50% of my unpaid balance including interest charges of 18.5% to the collection agency in addition to my balance. The collection agency may use any and all information given including cell phone numbers to collect.
3. In the event that it is necessary to commence legal action to collect this bill, I agree to pay all attorney's fees and all court costs.

Responsible Party Signature: _____ **Date:** _____

Relationship to Patient: Self Father Mother Guardian

I give Dr. Will Ellingson permission to treat my minor child in my absence.

Signature of Parent/Guardian _____ Date: _____