W | D
Willden Family Dental

10654 S. River Heights Dr.
Suite 330
South Jordan, UT 84095
(801) 446-4668 Office
(801) 446-6037 Fax

It is a pleasure to serve you! Please fill out the forms completely. If you have any questions, please ask.

Patient Information

Name _____
Last First MI
Prefer to be called _____ Male❒ Female ❒
HM#_____ **Cell #**_____---_____
WK# _____Ext._____
Best Place and time to be reached _____
Birthdate_____/_____/_____ Age _____
SS#_____
Home address _____
_____
City State Zip
Rent ❒ **Own ❒** How Long ?? _____

E-Mail_____

❒Single ❒Married ❒Widowed ❒Divorced ❒Separated

Employer _____
Wk #_____ Ext._____
Occupation _____ How Long? _____
Other family members seen by us _____

If Patient is a minor

Guardians Name_____
Address_____
_____
City State Zip
HM#_____ **Cell#** _____
WK# _____Ext._____
SS# _____Birthdate_____

Primary Dental Insurance

Insurance name _____
Insurance company address _____
_____
Insurance company phone # (____)_____
Group # _____Member #_____
Insured's name _____
Relationship to patient _____
Insured's Birthdate ____/____/____ SS # _____

Secondary Dental Insurance

Insurance company name _____
Insurance company address _____
_____
Insurance company phone # (____) _____
Group # _____Member #_____
Insured's name _____
Relationship to patient _____
Insured's birthdate ____/____/____ SS # _____

Spouse Information

Name _____
HM#_____ **Cell#** _____
Birthdate___/_____/_____ SS#_____
Employer _____ How Long_____
WK# _____ Ext. _____

In the Event of an Emergency

Friend or Relative not living with you:
Name _____
Relationship _____
HM#_____ **CELL#**_____

Please help us keep our fees low by coming to each appointment on time. When a change of appointment is necessary, 48 hours advance notice is requested. This enables us to offer this time to other patients who need our services. **If you miss more than 2 appointments, you will need to hold your future appointments with a credit card.**

I authorize payment of my insurance benefits directly to Dr. Willden. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the release of any information concerning my medical history, illness, or injuries to insurance carriers. A photocopy of this authorization shall be as valid as the original.

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the Federal Truth in Lending Act…please be advised of the following office policies in connection with the extension of credit. By signing the agreement, the responsible party agrees to:

1. Pay in full each time services are rendered, or by previous agreement. We accept cash, checks, Visa, Master Card, Amex, & Discover.
2. Pay 1.75% per month (21% APR) on any unpaid balance over 30 days past due, with a $3 minimum.
3. Authorized a credit bureau report to be obtained when deemed necessary.
4. Grant Permission to you or your assigned to phone me at my home or my workplace to discuss matters related to treatment or account.
5. Agree to pay the remaining balance due plus a 40% Collection Fee on my delinquent account if assigned with a collections agency. I also agree to pay any court costs and reasonable attorney fees if my account is assigned, with or without suit.

Signed: _____ Date: _____

Health History

Your current physical health is: ❑Good❑Fair❑Poor **Referred by:** _____

Are you now under the care of a physician? ❑ Yes ❑ No

Please explain _____

Name of the physician: _____ Phone: _____

Do you have any other health problems that need further clarification? ❑ Yes ❑ No

If yes, please explain: _____

Please list any prescription , diet, or over the counter drugs. _____

_____

Have you ever taken weight reduction (**diet pills**) ❑Yes ❑ No

❑ Fen-Phen(Fenfluramine+ Phentemine) ❑ Pondimin(Fenfluramine) ❑ Redux(Dexfenfluramine)

Have you been examined to ensure that you heart valves were not affected? ❑ Yes ❑ No

Have you had any unusual or **allergic reactions** to any of the following?

❑ Penicillin ❑ Erythromycin ❑ Tetracycline ❑ Codeine ❑ Local Anesthetic
❑ Aspirin ❑ Latex ❑ Metals ❑ Acrylic ❑ Non-Steroidal Anti-Inflammatories
❑ Pollen, etc ❑ Other narcotics ❑ Other Drugs _____

Do you have or have you EVER had any of the following. Please check those that apply.

❑ Heart Attack
❑ Angina
❑ Arrhythmia
❑ Pacemaker
❑ Heart Murmur
❑ Artificial Valve
❑ Rheumatic Fever
❑ Endocarditic
❑ Artificial Joints
❑ Hepatitis A
❑ Hepatitis B
❑ Hepatitis C
❑ Venereal Disease
❑ Jaundice
❑ Cirrhosis

❑ Kidney Disease
❑ Dialysis
❑ Thyroid Problems
❑ Alzheimer's
❑ Blood Disorder
❑ Anemia
❑ Excessive Bleeding
❑ Easy Bruising
❑ Fainting
❑ Convulsions
❑ Epilepsy
❑ Stroke
❑ Nervous Breakdown
❑ Emotional Problems
❑ Depression

❑ Tuberculosis
❑ Asthma
❑ Emphysema
❑ Chronic Cough
❑ Stomach Ulcers
❑ Intestinal Disease
❑ Chronic Diarrhea
❑ Eating Disorders
❑ Diabetes
❑ Glaucoma
❑ Arthritis
❑ Sinus Trouble
❑ Tumors
❑ Cancer
❑ Radiation Treatment

❑ Chemotherapy
❑ HIV or AIDS
❑ Alcoholism
❑ Drug Habit
❑ High Blood Pressure
❑ Low Blood Pressure
❑ ___/___ Avg. Blood Pressure
❑ Congestive Heart Failure
❑ Trouble Breathing-Reclined
❑ Swollen Ankles/Feet
❑ Mitral Valve Prolapse
❑ Internal Prosthetic Device
❑ Sores in mouth or on lips
❑ Immune System Disorder
❑ Other Serious Conditions

Dental History

Have you ever had a serious/difficult problem associated with previous dental work? ❑Yes ❑No

If yes, please explain _____

Have you ever had any pain or discomfort in you jaw joint (TMJ / TMD)?

Please explain _____

Date of last Dental Visit? _____ Reason for visit: _____

How often do you brush: _____ Floss: _____ Do your gums ever bleed? ❑Yes ❑ No

ARE YOU HAPPY WITH YOUR SMILE?? _____

I understand the medical and dental history information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should Further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

_____ _____

Signature Date

Willden Family Dental, Inc

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Dr. Ryan H. Willden's Notice of Privacy Practices.

Print Name Signature Date

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This form authorizes us to use and disclose your protected health information for the purposes of healthcare operations, treatment and payment activities. Before signing, please read our Notice of Privacy Practices to gain a clear understanding of how we may use and disclose your protected health information.

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. 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.

Signature Date

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____ Date_____

Relationship to Patient:_____

CONSENT TO PROCEED

I authorize Dr. Ryan H. Willden, DDS 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.

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. 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 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, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

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 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:_____

Willden Family Dental Insurance and Financial Policy Agreement

Please understand we are desirous to extend care to you and to work with you and any insurance coverage you may have.

1. Professional services are rendered to you, the patient, and not to the insurance company. Thus, the insurance company is responsible to the patient, 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. I understand that the amount of benefits to be derived under my part icular policy is a pre-determined arrangement between my employer and the Insurance Company.
3. For my convenience, Willden Family Dental will **ESTIMATE** the portion of your total fee that your Insurance Company will cover. This is **JUST AN ESTIMATE**. After insurance benefits, I am responsible for ANY UNPAID BALANCE. Willden Family Dental will ask you to pre-pay, or bring with you at the time of treatment, the **ESTIMATED** uncovered portion of the total fee.
4. I understand if I cancel an appointment within 24 hours of appointed time, or miss a scheduled appointment, I may be subject to a $125 per hour charge at Willden Family Dental's discretion based on my allotted appointed time.
5. If a check made by me to Willden Family Dental comes back due to insufficient funds, I agree to pay the amount of the check returned as well as any returned check fee(s) that may apply.
6. A finance charge of 1.75 % per month will be added to my bill if payment has not been received at Willden Family Dental within 60 days of my treatment date.
7. Should Collection become necessary (collection meaning any balance debt owed to Willden Family Dental not paid within 120 days from treatment), I agree to pay an additional collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I understand and also agree Willden Family Dental may send a collector agent to my residence or work to deliver any necessary collection documents.
8. I authorize my Insurance Company to make payment directly to Willden Family Dental for services rendered and agree to pay any uncovered balance. I hereby authorize release of information for insurances purposes.
9. Our policy requires a fee to be paid at time of treatment. Payment options: Check-Visa-MasterCard-Care Credit-American Express-Flex Accounts-Cash

Thank you for your understanding in this matter.
Signing below confirms acceptance of the above terms and Financial Policy.

Patient Name (Printed) Date

Signature of Patient if Over 18 Signature of Guardian if under 18