Larsen Family Dental
415 Medical Dr. Ste D-201
Bountiful, UT 84010
(801) 295-8881

PATIENT INFORMATION

Name:_____Sex: Male/Female

Last First Middle Initial Nickname

Birth Date_____Age_____SS#_____

Address_____City_____State____Zip_____

Cell Phone_____Work Phone_____Home Phone_____

Please check the box below to give your consent and opt in to receive text messages from Larsen Family Dental. By opting in, you agree to receive appointment reminders, important updates, and feedback requests via text message. Standard messaging rates may apply.

☐ Yes-Opt in for text messages. ☐ No-Opt out for text messages.

Email Address_____

Check Appropriate Status: __Single __Married __Divorced __Widowed __Separated

Emergency Contact:_____Relationship:_____Phone#_____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY IF PATIENT IS UNDER 18

Name of Responsible Party_____

Birth Date_____Age_____SS#_____

Relationship to Patient_____

Cell Phone_____Work Phone_____Home Phone_____

Address_____City_____State____Zip_____

DENTAL INSURANCE

Do you have Dental Insurance? Y/N If Yes, Name of Policy Holder_____

Dental Provider _____

Policy Holder Date of Birth_____Policy Holder SS#_____

***Please present your insurance card to receptionist*.**

I hereby certify that the information provided above is accurate to the best of my knowledge.

Signature: _____ **Date**_____

CONSENT TO PROCEED

I authorize DR. PAUL LARSEN and/or such associates or assistants as he may delegate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or 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 pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that 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 as part of the dental treatment, including preventative procedures such as cleaning 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 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 give the opportunity to ask questions.

_____ _____ _____

Signature of patient, parent or guardian | Date | Relationship to Patient

OFFICE FINANCIAL POLICY

In consideration for the professional services to be rendered to me, or at my request, to my minor child or ward, by the dentist, I agree to pay the fees charged for the dental services provided to the dentist or his/her assignee at the time the services are rendered, or within five days of billing if credit shall be extended. I further agree to pay the remaining balance plus reasonable attorney fees, court costs, and a collection agency commission of 33.3% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc, the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments, and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financial identifiable information and treatment descriptions and information either electronically, by facsimile or in paper form to my insurance carrier or any related entities that may require such information to be submitted.

I acknowledge that I have received a copy of this office's privacy policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

Patient must give a 24 hour notice to cancel or reschedule an appointment or a $25 cancelation fee will be applied to your account.

I certify that I have read and understand this form to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Signature of patient, parent or guardian | Date | Relationship to Patient

PATIENT MEDICAL HISTORY
(Under 18)

Patient Name_____
Primary Care Physician_____

1. What is your most important concern today?_____
2. How long ago did you last see a dentist?_____
2. Do you consider yourself to be in good health? Yes / No
3. Are you now or have you been under a physicians care within the past year? Yes / No
4. Do you take any medications, including birth control pills? Yes / No
   Please specify name and purpose of medications_____
   _____
5. Do you have or have you ever had any heart or blood problems? Yes / No
6. Have you ever been told you have a heart murmur? Yes / No
7. Do you require antibiotic pre-medication for a heart condition, artificial valve, or artificial joint? Yes / No
8. Do you have or have you ever had high blood pressure? Yes / No
9. Do you bleed or bruise easily? Yes / No
10. Have you ever been diagnosed as being HIV positive or having AIDS? Yes / No
11. Have you ever had hepatitis or liver disease? Yes / No
12. Have you ever had any systemic diseases, or any blood disorders? Yes / No
    If yes, please explain:_____
13. Do you have any food or drug allergies? Yes / No
    If yes, please explain:_____
14. Do you have any other allergies? If YES, please describe_____ Yes / No
15. Are you subject to fainting? Yes / No
16. Have you ever had any severe reaction to dental treatment or local anesthetics? Yes / No
17. Have you had a nervous breakdown or undergone psychiatric treatment? Yes / No
18. Have you received counseling for use of alcohol and/or prescription drugs? Yes / No
19. Women: Are you pregnant? Yes / No
20. Did you have or have you ever had bleeding or sensitive gums? Yes / No
21. Have you ever used or are you now using tobacco or alcohol? Yes / No

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES IN MY MEDICATIONS OR MEDICAL CONDITION AT ANY SUBSEQUENT APPOINTMENT SINCE IT MAY AFFECT MY DENTAL TREATMENT. I ALSO CERTIFY THAT I HAVE RECEIVED A COPY OF THE OFFICE PRIVACY POLICIES.

Signature_____Date_____
(PATIENT, LEGAL GUARDIAN OR AUTHORIZED AGENT OF PATIENT)

Reviewed_____ Date_____ Reviewed_____ Date_____ Reviewed_____ Date_____