HOLT DENTAL CARE

PATIENT INFORMATION

Date: ______

Patient's Name: ______ Birth date: ______ Age: ______

Address: ______ City: ______ Zip Code: ______

Sex (Circle): **M F** Social Security # ______ Email Address: ______

Home Phone # ______ Business # ______ Cell # ______

Patient's Employer: ______ Marital Status (Circle): **M S W D**

Is patient a full time student? **Y N** Name of School: ______

Spouse's Name: ______ Spouse's Soc Sec # ______

Person to contact in case of an emergency: ______

Address: ______ Phone # ______ Relationship: ______

Referred by: ______

GUARANTOR INFORMATION

Name of responsible party: ______ Relationship: ______

Address: ______ City: ______ Zip Code: ______

Home Phone # ______ Social Security # ______

Employer: ______

Employer's Address: ______ City: ______ Zip Code: ______

Business Phone # ______

Will dental insurance be involved? ______

PATIENT INSURANCE INFORMATION

Subscriber's Name: ______ Social Security # ______

Relationship to the Subscriber (Circle): **Self Spouse Child Other**

Name of Insurance Company: ______ Subscriber ID# ______

Insurance Address: ______ Subscriber DOB: ______

Phone # ______ Group # ______

SECONDARY INSURANCE

Subscriber's Name: ______ Social Security # ______

Relationship to the Subscriber: **Self Spouse Child Other**

Name of Insurance Company: ______ Subscriber ID# ______

Insurance Address: ______

Phone # ______ Group # ______

Joshua C. Holt, D.D.S. | 3855 West 7800 South, Suite 250, West Jordan, Utah 84088 | PH: 801-282-5839 | www.HoltDentalCare.net

NEW PATIENT FORM CONTINUED...

DENTAL/MEDICAL HISTORY (Confidential)

HEALTH INFORMATION

Please indicate YES or NO		
Are you in good health	____	____
Do you presently have pain	____	____
Are you under physician's care now	____	____
Have you ever had:		
Abnormal heart condition	____	____
Artificial valve	____	____
Rheumatic fever	____	____
Used Fen Phen	____	____
Diabetes	____	____
Abnormal bleeding	____	____
Artificial joint	____	____
Unusual reaction to any drug or Local Anesthetic	____	____
Smoking and/or Tobacco	____	____
Asthma	____	____
Allergies (Specify)	____	____
Abnormal Blood Pressure	____	____

Please indicate YES or NO		
Tuberculosis	____	____
Radiation Treatment	____	____
Blood Thinners (i.e. Coumadin)	____	____
Hepatitis	____	____
Blood transfusion (Give date)	____	____
Venereal disease	____	____
AIDS or HIV positive	____	____
Bisphosphonates (i.e. Fosamax)	____	____
Jaw joint pain, clicking, etc	____	____
Females, are you pregnant	____	____
Females, are you taking oral contraceptives (Antibiotics Render oral contraceptives ineffective)	____	____
Is there any other information about your health we should know	____	____

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical conditions or medications can affect dental treatment, I understand the importance of and agree to notify the dentists of any changes are any subsequent appointment.

Signature: Date:

INFORMED CONSENT

I authorize Dr. Holt 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 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, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of 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. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any 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 for 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.

AUTHORIZATION AND RELEASE

I authorize the dentist to release information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby do abide by the conditions outlined here in.

Signature: Date:

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