Booth Dental Clinic

1245 Capitol Street, Suite 101-S • Ogden, Utah 84401

Dr. Gregory Booth Dr. Paul S. Booth

PATIENT INFORMATION

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. (Particularly on the reverse side.) Thank you for your cooperation.

I. PERSONAL

Patient's Name _____ Date _____
(Full Name)

Birthdate _____ Age _____ SS # _____ Marital Status: S/M/D/W

Person Responsible for Account _____
(Complete Name)

_____
(Relationship) Social Security Number Date of Birth

Home Address _____ Phone _____

City, State & Zip _____ Cell Phone _____

Email Address _____

Previous Address if within 3 years _____
City, State & Zip

Present Employer _____ Occupation _____

Business Address _____ Phone _____

Spouse's Name _____

Spouse's Employer _____

Name of nearest adult relative not living with you _____

Address _____ Phone _____

Whom may we thank for referring you? _____

II. INSURANCE & ADDRESS

Name of Primary Dental Insurance Plan _____

Name of Insured _____

Group No. _____ Membership No. _____ Birthdate of Insured _____

Name of Secondary Dental Insurance Plan _____

Name of Insured _____

Group No. _____ Membership No. _____ Birthdate of Insured _____

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous agreements.
2. That if payments are extended beyond 90 days from the date of first billing to pay 1 1/2 per month on the unpaid balance (annual rate of 18%) with a minimum charge of 50¢ per month.
3. Pay the doctor the usual fee for broken appointments.

I/we agree to pay cost and/or reasonable attorney's fee, and a forty percent (40%) collection fee, if any delinquent balance is placed with an agency or attorney for collection or suit.

_____ _____

Date Signature: Responsible Person

See Reverse Side

(Rev. 1/2013)

Health History

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Phone: _____

Yes No 1. Are you having pain?
Yes No 2. Are you in good health?
Yes No 3. Have you been under a physician's care in the past 2 years?
Yes No 4. Do you take medications? If yes, please list: _____
_____

Yes No 5. Are you allergic to penicillin, codeine, local anesthetic or any other drugs?
If so, please specify: _____
Yes No 6. Do you have any sensory impairment including vision or hearing?
Yes No 7. Are you pregnant?
Yes No 8. Have you ever had any heart or blood problems?
Yes No 9. Have you had joint replacements? (i.e. hip, knee)
Yes No 10. Have you ever had a heart valve replacement?

11. Have you ever had? (Circle for Yes)

Anemia	High / Low Blood Pressure	Sinus Infections
Arthritis	Kidney Disease	Stomach Problems
Asthma, Lung Disorders	Liver Disease	Stroke
Blood Disorders	Diabetes	Venereal Disease

Autoimmune System Disorders, specify_____

Yes No 12. Have you ever taken Fosamax, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis?
Yes No 13. Do you use tobacco products?
14. On an average, how many ounces of soda pop or energy drinks do you consume daily?_____
Yes No 15. Have you ever been diagnosed with Hepatitis, AIDS or any other infectious disease?
Yes No 16. Do you bruise or bleed easily?
Yes No 17. Are you happy with your smile?
Yes No 18. Do you snore?
19. Do you have any other health or medical conditions that you are aware of? If so, please specify: _____

If this is your first visit in our office:
Have you ever had any reaction to dental treatment? If so, please specify_____
Who was your last dentist and when did you visit them last? _____
Were X-rays taken at that time? _____
Reason for today's visit: _____
Please add anything you feel is important. _____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Booth and/or such associates or assistants as she/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 whom 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, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

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.

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____