



Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Phone: 385-335-2644

Gclcfamilydentalcare@gmail.com

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____
Address _____ City _____ State _____ Zip _____
Sex [] M [] F [] Married [] Widowed [] Single [] Minor
[] Separated [] Divorced [] Partnered for _____ years Preferred Appointments _____
Home Phone _____ Cell Phone _____ Email _____
Employer _____ Employer Phone _____
Employer Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____ What's the best way to reach you? _____
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone _____
Birthdate _____ Currently a patient in our office? [] Yes [] No
Employer _____ Work Phone _____
E-Mail _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Subscriber _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone # _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Subscriber ID _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

PAYMENT AND MISSED APPOINTMENT POLICY

Payment is due in full at time of treatment unless prior arrangements have been approved. If an appointment is missed without 24 hours notice, a \$40 charge will be applied to your account.

"I agree to pay interest at the rate of 1.5% a month (18% annually) on all account balances owing more than 30 days from the date the dental services were provided, plus court costs and reasonable attorneys' fees, with or without a suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency as provided by Utah law. I also agree to pay missed appointment fees."

Signature of Patient, Parent, Guardian, or Personal Representative _____ Date _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have or have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine).

Have you ever had any serious illnesses or operations?? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had problems with any of the following:

- | | | | |
|---|--|---|--|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart lesions | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> <input type="checkbox"/> Back Problems | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> <input type="checkbox"/> Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Heart Problems | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever | |

List medications you are currently taking: _____

Allergies:

- | | | | |
|---|--|--|---|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> <input type="checkbox"/> Iodine | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> <input type="checkbox"/> Latex | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Codeine | <input type="checkbox"/> <input type="checkbox"/> Sulfa | <input type="checkbox"/> <input type="checkbox"/> None | |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

Signature of of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.