Spring Creek Dental Associates, LLC

274 North Spring Creek Parkway, Providence, UT 84332
435-713-0096

Patient Name_____Birth Date_____
Last First Middle

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other

Email address_____ Social Security #_____

My mobile phone # is _____ Home Phone _____Work_____
_____ (Please Initial) I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

Address_____
Street Apt. #

_____
City State Zip Code

Have you ever had any of the following? Please check those that apply:

☐Aids
☐Allergies_____
☐Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disorders
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Tuberculosis
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Any Heart Conditions _____
☐ Severe Congenital Heart Defect
☐ Have you been told a premed is needed before dental work
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Other Allergies _____
☐ Are you pregnant? due date_____

*Are you taking any medication now? ☐ Yes ☐ No
If yes, please explain:_____
*Have you ever had any complications following dental treatment? ☐Yes ☐ No
If yes, please explain:_____
*Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐ No
If yes, please explain:_____
*Are you under the care of a Physician? ☐ Yes ☐ No
If yes, please explain:_____
*Name of Physician:_____
*Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____
In case of emergency who may we contact?

_____
Name Relationship Address Phone Number

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

TURN PAGE OVER

Referral Information

Whom may we thank for referring you to our practice? ▢ Another patient, friend ▢ Another patient, relative
▢ Dental Office ▢ Yellow Pages ▢ Radio ▢ Internet ▢ Work ▢ Insurance ▢ Walked By ▢ Other_____
Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for the person responsible for payment:
Name of Parent, Guardian or self: _____
Name of Employer: _____ Occupation:_____
Employer Address: _____
Street City State Zip Code

Primary Dental Insurance Information

Name of Insurance Company: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Subscriber Address: _____
Street City State Zip Code
Policy # or Subscriber ID#:_____ Group #: _____
Dental Claims address: _____
Street or P.O. Box City State Zip Code
Insurance Phone # _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services or any dental services performed without previous financial arrangements, must be paid for in cash at the time of service. An 18% interest will be charged on overdue accounts past 60 days. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

The dental treatment necessary to my existing oral condition(s) has been explained to me and my questions have been answered satisfactorily. I herby authorize the doctor and/or such associates or assistants as they may designate to perform these procedures, including surgery, analgesic, therapeutic and /or other pharmaceutical agents, including those related to restorative, palliative, surgical, anesthetic, sedative, analgesic, medicinal or drug treatment(s) and do voluntarily assume the possible risks with these procedures. I understand that the fee estimate listed for this dental care can only be extended for six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

_____Date:_____Relationship to Patient_____
Signature of patient, parent or guardian