

*Chad S. Burt D. M. D.  
Kyle W. Dimond D.D.S.*

***Patient Registration***

**Patient Information:**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security: \_\_\_\_\_

(Check appropriate box: Minor  Single  Married  Divorced  Widowed  Separated  Other

Employer: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

**Spouse or Responsible Party Information:**

Name of Responsible Party (guardian): \_\_\_\_\_

Address (if different than patient): \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Name of nearest relative not living with you: \_\_\_\_\_

Address: \_\_\_\_\_ City State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Dental Insurance Information:**

Insurance Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Secondary Dental Insurance Information:**

Insurance Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Payment Agreement:**

By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred for myself or my dependent. I understand that it is my responsibility to provide my correct/ updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is, and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I hereby authorize the insurance to assign payment directly to the doctor(s) for services rendered. I further authorize the doctor(s) to release all information necessary to secure the payment of benefits, and the use of this signature on all insurance submissions.

**Consent for Services:**

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. Burt/Dr. Dimond 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 or the 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 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, muscle soreness, and temporary or rarely permanent numbness.

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 understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and /or pressure for an extended period of time.

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.

I grant my permission to you or your assignee to telephone me at home or at my work, or on my cell phone to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent, guardian, or responsible party

Date

\_\_\_\_\_  
Relationship to patient

## MEDICAL HISTORY

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain \_\_\_\_\_

Are you taking any medications, pills or drugs?  Yes  No If yes, please explain \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No

Are you on a special diet?  Yes  No Women: Are you:

Do you use tobacco?  Yes  No  Pregnant/Trying to get pregnant?  Nursing?

Do you take, or have you taken Fosamax?  Yes  No  Taking oral contraceptives?

Are you allergic to any of the following:

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other If yes, please explain \_\_\_\_\_

Do you have, or have you had, any of the following?

|   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> Aids/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapsed | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B & C       | <input type="checkbox"/> Radiation Treatments   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain \_\_\_\_\_

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ Date \_\_\_\_\_

Chad S. Burt D.M.D.  
Kyle W. Dimond D.D.S.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgement

I, \_\_\_\_\_, have read a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement.

An emergency situation prevented us from obtaining acknowledgement.

Other ( Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_