GRANITE VIEW DENTAL

Dr. Will Ellingson, DMD
850 E. 9400 S. Suite 100
Sandy, Utah 84094
801-255-2100

Welcome to our office!

PATIENT INFORMATION

Full Name: _____ Date: _____
Last *First* *M.I.*

Preferred Name: _____ ○ Single ○ Married ○ Divorced ○ Widowed ○ Other ○ Male ○ Female

Address: _____
Street Address *City* *State* *Zip*

Home Phone: _____ Cell Number: _____ Email Address: _____

Birthday: ___/___/___ Social Security#.: _____ Drivers License#: _____

Employer: _____ Employer Address: _____
Street City State Zip

Emergency Contact Name: _____ Relation: _____ Number: _____

Other family members seen by us: _____ Who can we thank for referring you? _____

SPOUSE INFORMATION

His/Her Name: _____

Birthday: ___/___/___ SSN: _____

Employer: _____

Phone: _____ Email: _____

RESPONSIBLE PARTY FOR ACCOUNT

Name: _____ Relation: _____

Address: _____
Street City State Zip

Phone: _____ SSN: _____

Employer: _____

Primary Dental Insurance

Insurance Co. Name: _____ Phone: _____ Group # (Plan, Local, or Policy#) _____

Insurance Address: _____
Street City State Zip

Insured Name: _____ Insured SSN: _____ Insured Birthday: ___/___/___ Relation: _____

Insured Employer: _____ Employer Address: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: _____ Group # (Plan, Local, or Policy#) _____

Insurance Address: _____
Street City State Zip

Insured Name: _____ Insured SSN: _____ Insured Birthday: ___/___/___ Relation: _____

Insured Employer: _____ Employer Address: _____

Dental History

Why have you come to the dentist today?_____

_____

Are you currently in pain? Yes ☐ No ☐

Do you require antibiotics before dental treatment? Yes ☐ No ☐

Have you experienced problems associated with any previous dental work? Yes ☐ No ☐

Do you now or have you ever experienced Pain/discomfort in your jaw joint (TMJ/TMD)? Yes ☐ No ☐

Do you or have you been told you snore? Yes ☐ No ☐

Do you feel tired during the day? Yes ☐ No ☐

Do you use anything in addition to your brush and floss? Yes ☐ No ☐

If yes, what? _____

Would you like whiter teeth? Yes ☐ No ☐

Previous Dentist? _____ Last Visit _____

Address: _____ Phone: _____

Why did you leave your previous dentist? _____

_____

Do you still have wisdom teeth? Yes ☐ No ☐

Are you happy with your smile? Yes ☐ No ☐

If not, what would you change? _____

_____

Do your gums ever bleed? Yes ☐ No ☐

Have you ever had periodontal disease? Yes ☐ No ☐

Do you have mobility in your teeth? Yes ☐ No ☐

Are your teeth sensitive to heat, cold or anything else? Yes ☐ No ☐

Medical History

Do you have a physician? Yes ☐ No ☐

Physician's name: _____

Address: _____

Phone #: _____ Last Visit Date: _____

Your current physical health is: Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a Physician? Yes ☐ No ☐

Please explain: _____

_____

Do you smoke or use tobacco in any other form? Yes ☐ No ☐

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry/Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list any additional drugs/materials that cause allergic Reactions: _____

Women Only: Are you taking birth control pills? Y N

Are you pregnant? Unsure ☐ Yes ☐ No ☐ Week #: _____

Are you nursing? Yes ☐ No ☐

ARE YOU TAKING THE FOLLOWING?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drug	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drug	Have you ever taken Phen-Fen? Also
Y N Aspirin	Y N Digitals/Heart Medication	Y N Steroids/Cortisone	Known as Redux or Pondimin. Y N

Are you taking any prescription, over the counter drugs, herbal remedies, or minerals not listed above? Yes ☐ No ☐

If yes please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Lupus	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Mitral Valve Prolapse	Y N Stroke
Y N Asthma	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Thyroid Problems
Y N Blood Transfusion	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Tonsillitis
Y N Chicken Pox	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Problems	Y N Tuberculosis (TB)
Y N Artificial Valves	Y N Fever Blisters	Y N HIV/Aids	Y N Radiation Treatment	Y N Ulcers
Y N Cancer	Y N Glaucoma	Y N Hospitalized	Y N Scarlet Fever	Y N Venereal Disease
Y N Chemotherapy	Y N Hay Fever	Y N Kidney Problems	Y N Seizures	

I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status.

_____ _____

Print Name Signature Date

Dr. Will Ellingson, DMD

850 E. 9400 S. Ste 100

Sandy, Utah 84094

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GRANITE VIEW DENTAL

Consent To Proceed

I authorize Dr. William Ellingson D.M.D. 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, and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic or surgical treatments.

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

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

I understand that as a part of the dental treatment, including preventative procedures such as cleanings, and basic dentistry including fillings of all types, teeth may be sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including but not limited to crowns, small dental instruments, drill components, etc., may be aspired (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

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.

Patient Name: _____

Signature: _____ **Date:** _____

(patient, legal guardian or authorized agent of patient)

Witness: _____ **Date:** _____

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Financial Policy

Thank you for selecting us as your dental health care provider. The following information describes our Financial Policy.

Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask.

Payment is due at the time services are rendered. This includes non-covered fees and co-pays, unless payment arrangements have been approved prior to the day of your appointment.

- We accept cash, checks, MasterCard, Visa, Discover, American Express, and Care Credit.
- A bill becomes delinquent after 60 days of no activity.
- A $25 fee will be charged on all returned checks.
- Patients who do not cancel their scheduled appointments 48 hours prior to the scheduled time, will be charged a fee of $50 per hour.

Note: Insurance is not a guarantee of coverage. As a courtesy to our patients we will submit claims to the insurance company provided.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING

1. I agree that I am responsible for this debt regardless of my insurance and that I will pay any unpaid balance in full within 60 days of the date of service. I also agree to pay 18.5% interest pre annum on the unpaid balance.
2. In the event that my account is not paid as agreed, I agree to pay a collection fee up to 33.3% of my unpaid balance to the collection agency in addition to my balance. The collection agency may use any and all information given to collect.
3. In the event that it is necessary to commence legal action to collect this bill, I agree to pay all attorney's fees and all court costs.

Responsible Party Name (please print): _____

Signature: _____ **Date:** _____

Relationship to Patient: Self Father Mother Guardian

I give Dr. Will Ellingson permission to treat my minor child in my absence.

Signature of Parent/Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of **Granite View Dental.**

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us (801-255-2100).

I acknowledge receipt of the notice of Privacy Practices of **Granite View Dental.**

Patient's Name: _____

Signature: _____ Date: _____
(Patient/parent/conservator/guardian)

Witness: _____ Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patients Name: _____

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

☐ Other: _____