Jordan Valley DENTAL

Dr. Brigham G. Colton, DMD
Dr. Kyle J. Baldwin, DDS

Patient Information

Patient Legal Name: _____ (Last / First / MI) Preferred Name: _____

☐ Married ☐ Single ☐ Child ☐ Widow ☐ Other Date of Birth: _____ (month / day / year) Age: _____ ☐ Male ☐ Female

Address: _____ (Street) SSN: _____

_____ (City / State / Zip) Cell Phone: _____

E-Mail Address: _____ Alternate Phone: _____

Emergency Contact: _____ (Name / Phone / Relationship)

Person Responsible for Payment of this Account

☐ I am the patient and I am18 or older and am responsible for my own account. (Please fill out Employer Information)

☐ The patient listed above is under 18 or for another reason I am responsible for this account.

My Relationship to the Patient above is: ☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Other: _____

Name of Responsible Party: _____ (Last / First / MI) SSN: _____

Address: _____ (Street) Date of Birth: _____

_____ (City / State / Zip) Cell Phone: _____

Employer: _____ Occupation: _____

Address: _____ (Street) Years Employed: _____

_____ (City / State / Zip) Employer's Phone: _____

Primary Insurance Information

Policy Holder's Legal Name: _____ (Last / First / MI) SSN: _____

Insurance Company: _____ Date of Birth: _____

Policy ID #: _____ Group #: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Secondary Insurance Information

Policy Holder's Legal Name: _____ (Last / First / MI) SSN: _____

Insurance Company: _____ Date of Birth: _____

Policy ID #: _____ Group #: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient referred me: Name of Referral _____

☐ Another Dental Office ☐ Internet Search ☐ Flier or Advertisement ☐ Insurance Company ☐ Website ☐ Other

Medical History

- When was your last physical examination?_____ Do you consider yourself to be in good health? ☐ Yes ☐ No
- Are you now, or have you been under a physician's care within the past year? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician:_____ Specialty:_____ Phone Number:_____
- Are you currently taking any medications (including birth control pills)? ☐ Yes ☐ No
  If yes, please list name and purpose of medications:_____
- Are you allergic to any drugs, medications, or local anesthetics? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you require antibiotics prior to receiving dental treatment for a heart condition, artificial heart valve, or artificial joint? ☐ Yes ☐ No
- Women, are you pregnant? ☐ Yes ☐ No Which Trimester? ☐ First ☐ Second ☐ Third Due Date:_____
- Have you ever taken Fosamax, Actonel, Boniva, or any other osteoporosis / bone cancer medications? ☐ Yes ☐ No
- Are you currently using tobacco? ☐ Yes ☐ No If yes, what type? ☐ Smoke ☐ Chew ☐ Vape Are you trying to quit? ☐ Yes ☐ No
- If you have quit using tobacco, how long did you use before quitting?_____ When did you quit?_____
- Do you drink alcohol? ☐ Yes ☐ No
- Have you ever received counseling for use of alcohol and/or prescription drugs? ☐ Yes ☐ No

Do you have, or have you ever had any of the following? Please check those that apply:

Genitourinary
- ☐ Kidney Disease
- ☐ Kidney Transplant
- ☐ Dialysis
- ☐ Herpes
- ☐ Venereal Disease

Blood, Lymph, & Immune
- ☐ Immune System Disorder
- ☐ Bruise Easily
- ☐ Excessive or Easy Bleeding
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Anemia
- ☐ HIV Positive
- ☐ AIDS
- ☐ Leukemia

Psychiatric
- ☐ Depression
- ☐ Nervous Breakdown
- ☐ PTSD

Heart & Blood Vessels
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Congenital Heart Disease
- ☐ Prosthetic Heart Valves
- ☐ Heart Surgery
- ☐ Pacemaker

Endocrine (Glands)
- ☐ Diabetes
- ☐ Thyroid Trouble

Respiratory
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Asthma

Nervous System
- ☐ Frequent Headaches
- ☐ Dizziness / Fainting
- ☐ Epilepsy / Seizures
- ☐ Paralysis / Numbness

Digestive System
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Intestinal Ulcers

Eyes, Ears, Nose, & Throat
- ☐ Loss of Hearing
- ☐ Frequent Ear Infections
- ☐ Sinus Problems

Bone & Muscles
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Osteoporosis

Other
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Stroke
- ☐ Fibromyalgia
- ☐ Autism

- Do you have any disease, condition, or problem not listed above that Dr. Colton should know about? ☐ Yes ☐ No
  If yes, please explain:_____

Dental History

- Purpose of today's visit:_____ Are you in pain? ☐ Yes ☐ No
- How long since your last dental visit?_____ Who was your previous dentist?_____
- Have you ever had an adverse reaction or unpleasant experience during dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you think that your teeth are affecting your general health in any way? ☐ Yes ☐ No
- Do you ever have bleeding or sensitive gums? ☐ Yes ☐ No
- Have you ever had a deep cleaning, scaling & root planing, or periodontal therapy? ☐ Yes ☐ No
- How often do you floss?_____ How often do you brush?_____
- What type of toothbrush do you use? ☐ Manual ☐ Power Are any of your teeth sensitive to hot or cold? ☐ Yes ☐ No
- Would you like to Demo an Oral-B power toothbrush today? ☐ Yes ☐ No
- Is there anything you would like to change about your smile? ☐ Yes ☐ No
  If yes, please explain:_____

I hereby certify that the answers to the forgoing questions are accurate to the best of my ability. Since a change in my medical condition or in medications I take can affect dental treatment, I understand the importance of and agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

_____ Date:_____ Relationship to Patient:_____
Signature of patient, parent, or legal guardian

Office Financial Policies & Federal Truth-In-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, 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 full at the time services are rendered.

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. Our office staff will prepare and send the insurance forms for our patients and or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, our dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 18% per month of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit shall be extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission; an additional 50%; charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. **Furthermore, I agree to give 24 hours notice if an appointment must be changed or cancelled. If I fail to give proper notice for myself or minor child, I agree to pay a $30.00 per hour cancellation fee; that is prorated according to the appointment length.**

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.
I hereby agree to abide by the conditions outlined herein.

_____ Date:_____ Relationship to Patient:_____

Signature of patient, parent, or legal guardian

Consent to Proceed with Services

I authorize Dr. Brigham G. Colton, DMD 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 that the administration of local anesthetic may cause an untoward reaction of 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. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of dental treatment, including preventative procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. 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 aspirated (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 understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

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.

Name of patient receiving services:_____

_____ Date:_____ Relationship to Patient:_____
Signature of patient, parent, or legal guardian

_____ Date:_____ Position:_____
Signature of witness

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