DR. MICHAEL LOESER D.M.D.

Account # _____ Date _____

PERSONAL

Patient's Name _____ **(Male) / (Female) PHONE NUMBER:** _____

Birth date _____ Age _____ Patients Social Security Number _____

PERSON RESPONSIBLE FOR THE ACCOUNT(complete name) _____

Relationship to patient _____ Social Security Number _____ Date of Birth _____

Home Address _____ City _____ Zip Code _____

Employer _____ Phone number _____

Spouses name _____ Date of Birth _____

Spouse's Employer _____ Phone Number _____

Name of nearest adult relative not living with you _____

Address _____ Phone _____

Whom may we thank for referring you? _____

(INSURANCE)

PRIMARY INSURANCE PLAN _____

Address _____ Name of Insured _____

Date of Birth _____ Social Security Number _____

Name of Employer _____ Address of Employer _____

Employer phone number _____ Insurance Group or Plan number _____

Policy or Membership number _____ Effective date _____

SECONDARY INSURANCE PLAN _____

Address _____ Name of Insured _____

Date of Birth _____ Social Security Number _____

Name of Employer _____ Address of Employer _____

Employee phone number _____ Insurance Group or Plan number _____

Policy or Membership number _____ Effective date _____

FINANCIAL AGREEMENT-(1.5% Interest will be charged per month for any amount over 60 days past due)

Payment due on appointment, (If we are billing your insurance company we will gladly "Estimate" your portion. We accept most major credit cards.) I authorize release of any information relating to this claim to my insurance companies, I also authorize insurance payments to be made directly to my dentist. If the account is assigned to an outside agency for collection, I / we agree to pay all attorney fees, court costs, and a collection charge of 40%, which will be added to the outstanding balance of my account.

DATE: _____/PATIENT OR LEGAL GUARDIAN SIGNATURE: _____

****

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE: (Circle one)

1. Are you in pain? ..... Yes No
2. Are you in good health? ..... Yes No
3. Are you now under the care of a physician? ..... Yes No
4. Do you take any medicine? If so for what? _____ Yes No
5. WOMEN: Are you pregnant? ..... Yes No
6. Have you ever had heart or blood trouble? ..... Yes No
7. Have you ever had hepatitis? ..... Yes No
8. Do you bleed or bruise easily? ..... Yes No
9. Are you allergic to Penicillin or any drugs and local anesthetics? If so what? _____
10. Are you subject to fainting? ..... Yes No
11. Have you ever taken Phen-Phen or any other diet pills? ..... Yes No
12. Have you ever had a severe reaction to a dental treatment? ..... Yes No
13. When did you see your dentist last? _____
14. Name of Medical Doctor _____ Phone number _____

Circle any of the following conditions which you have had:

HEART DISEASE	STROKE	DIABETES	TUBERCULOSIS	ULCER
HEART MURMUR	ASTHMA	EPILEPSY	LIVER DISEASE	HEPATITIS
ARTHRITIS	RHEUMATISM	JAUNDICE	RHEUMATIC FEVER	BLOOD DISORDER
SINUS TROUBLE	THYROID TROUBLE		HIGH BLOOD PRESSURE	KIDNEY DISEASE
VENEREAL DISEASE				

ANY OTHER CONSTITUTIONAL DISORDERS? (Please specify) _____

DR. CURTIS CONDIE D.D.S.

Account # _____ Date _____

PERSONAL

Patient's Name _____ **(Male) / (Female) PHONE NUMBER:** _____

Birth date _____ Age _____ Patients Social Security Number _____

PERSON RESPONSIBLE FOR THE ACCOUNT(complete name) _____

Relationship to patient _____ Social Security Number _____ Date of Birth _____

Home Address _____ City _____ Zip Code _____

Employer _____ Phone number _____

Spouses name _____ Date of Birth _____

Spouse's Employer _____ Phone Number _____

Name of nearest adult relative not living with you _____

Address _____ Phone _____

Whom may we thank for referring you? _____

(INSURANCE)

PRIMARY INSURANCE PLAN _____

Address _____ Name of Insured _____

Date of Birth _____ Social Security Number _____

Name of Employer _____ Address of Employer _____

Employer phone number _____ Insurance Group or Plan number _____

Policy or Membership number _____ Effective date _____

SECONDARY INSURANCE PLAN _____

Address _____ Name of Insured _____

Date of Birth _____ Social Security Number _____

Name of Employer _____ Address of Employer _____

Employee phone number _____ Insurance Group or Plan number _____

Policy or Membership number _____ Effective date _____

FINANCIAL AGREEMENT-(1.5% Interest will be charged per month for any amount over 60 days past due)

Payment due on appointment, (If we are billing your insurance company we will gladly "Estimate" your portion. We accept most major credit cards.) I authorize release of any information relating to this claim to my insurance companies, I also authorize insurance payments to be made directly to my dentist. If the account is assigned to an outside agency for collection, I / we agree to pay all attorney fees, court costs, and a collection charge of 40%, which will be added to the outstanding balance of my account.

DATE: _____/PATIENT OR LEGAL GUARDIAN SIGNATURE: _____

****

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE: (Circle one)

1. Are you in pain? ..... Yes No
2. Are you in good health? ..... Yes No
3. Are you now under the care of a physician? ..... Yes No
4. Do you take any medicine? If so for what? _____ Yes No
5. WOMEN: Are you pregnant? ..... Yes No
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7. Have you ever had hepatitis? ..... Yes No
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9. Are you allergic to Penicillin or any drugs and local anesthetics? If so what? _____
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12. Have you ever had a severe reaction to a dental treatment? ..... Yes No
13. When did you see your dentist last? _____
14. Name of Medical Doctor _____ Phone number _____

Circle any of the following conditions which you have had:

HEART DISEASE	STROKE	DIABETES	TUBERCULOSIS	ULCER
HEART MURMUR	ASTHMA	EPILEPSY	LIVER DISEASE	HEPATITIS
ARTHRITIS	RHEUMATISM	JAUNDICE	RHEUMATIC FEVER	BLOOD DISORDER
SINUS TROUBLE	THYROID TROUBLE		HIGH BLOOD PRESSURE	KIDNEY DISEASE
VENEREAL DISEASE				

ANY OTHER CONSTITUTIONAL DISORDERS? (Please specify) _____

DR. NICK J. RUDELICH D.D.S.

Account # _____ Date _____

PERSONAL

Patient's Name _____ **(Male) / (Female) PHONE NUMBER:** _____

Birth date _____ Age _____ Patients Social Security Number _____

PERSON RESPONSIBLE FOR THE ACCOUNT(complete name) _____

Relationship to patient _____ Social Security Number _____ Date of Birth _____

Home Address _____ City _____ Zip Code _____

Employer _____ Phone number _____

Spouses name _____ Date of Birth _____

Spouse's Employer _____ Phone Number _____

Name of nearest adult relative not living with you _____

Address _____ Phone _____

Whom may we thank for referring you? _____

(INSURANCE)

PRIMARY INSURANCE PLAN _____

Address _____ Name of Insured _____

Date of Birth _____ Social Security Number _____

Name of Employer _____ Address of Employer _____

Employer phone number _____ Insurance Group or Plan number _____

Policy or Membership number _____ Effective date _____

SECONDARY INSURANCE PLAN _____

Address _____ Name of Insured _____

Date of Birth _____ Social Security Number _____

Name of Employer _____ Address of Employer _____

Employee phone number _____ Insurance Group or Plan number _____

Policy or Membership number _____ Effective date _____

FINANCIAL AGREEMENT-(1.5% Interest will be charged per month for any amount over 60 days past due)

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DATE: _____ /PATIENT OR LEGAL GUARDIAN SIGNATURE: _____

****

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE: (Circle one)

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13. When did you see your dentist last? _____
14. Name of Medical Doctor _____ Phone number _____

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ARTHRITIS	RHEUMATISM	JAUNDICE	RHEUMATIC FEVER	BLOOD DISORDER
SINUS TROUBLE	THYROID TROUBLE		HIGH BLOOD PRESSURE	KIDNEY DISEASE
VENEREAL DISEASE				

ANY OTHER CONSTITUTIONAL DISORDERS? (Please specify) _____

DR. VICTOR O. PICKETT D.M.D.

Account # _____ Date _____

PERSONAL

Patient's Name _____ **(Male) / (Female) PHONE NUMBER:** _____
Birth date _____ Age _____ Patients Social Security Number _____
PERSON RESPONSIBLE FOR THE ACCOUNT(complete name) _____
Relationship to patient _____ Social Security Number _____ Date of Birth _____
Home Address _____ City _____ Zip Code _____
Employer _____ Phone number _____
Spouses name _____ Date of Birth _____
Spouse's Employer _____ Phone Number _____
Name of nearest adult relative not living with you _____
Address _____ Phone _____
Whom may we thank for referring you? _____

(INSURANCE)

PRIMARY INSURANCE PLAN _____
Address _____ Name of Insured _____
Date of Birth _____ Social Security Number _____
Name of Employer _____ Address of Employer _____
Employer phone number _____ Insurance Group or Plan number _____
Policy or Membership number _____ Effective date _____
SECONDARY INSURANCE PLAN _____
Address _____ Name of Insured _____
Date of Birth _____ Social Security Number _____
Name of Employer _____ Address of Employer _____
Employee phone number _____ Insurance Group or Plan number _____
Policy or Membership number _____ Effective date _____

FINANCIAL AGREEMENT-(1.5% Interest will be charged per month for any amount over 60 days past due)

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DATE: _____ **/PATIENT OR LEGAL GUARDIAN SIGNATURE:** _____

****

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1. Are you in pain? ..... Yes No
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3. Are you now under the care of a physician? ..... Yes No
4. Do you take any medicine? If so for what? _____ Yes No
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7. Have you ever had hepatitis? ..... Yes No
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13. When did you see your dentist last? _____
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HEART MURMUR	ASTHMA	EPILEPSY	LIVER DISEASE	HEPATITIS
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SINUS TROUBLE	THYROID TROUBLE		HIGH BLOOD PRESSURE	KIDNEY DISEASE
VENEREAL DISEASE				

ANY OTHER CONSTITUTIONAL DISORDERS? (Please specify) _____

Permission to contact via cellular telephone

We want to stay in touch with you regarding your account. Since most people only have cell phones, we will need your permission to call your cell phone. Signing this agreement will allow us to do that. Please let us know if you have any questions or would like to discuss this.

In order for us, or for any other person or entity who provides goods or services to you in connection with this agreement, to contact you regarding servicing your account(s). Including all past and current accounts, or to collect any amount you may owe for any past or current account(s), you expressly authorize us to contact you by telephone at any telephone number, including any cellular, mobile, and other wireless telephone numbers that you have or may attain. You acknowledge that such calls could result in charges to you by your telephone carrier. You also expressly authorize us, and any other person or entity that provides goods or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded/ artificial voice messages and/or the use of an automatic telephone dialing system, as applicable.

You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned your account(s) for servicing or collection.

I/We have read this disclosure and agree that I/we may be contacted as described above.

Signature:_____ Date:_____

_____

Print your name here

Southwest Dental
5255 S. 4015 W. Suite 180
Kearns, UT 84118

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree with my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient name:_____

Relationship to patient:_____

Signature:_____

Date:_____

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. This 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 cash at the time serves are rendered.

Patient who carry dental insurance understand that all dental services furnished are charged directly to the patients and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from the insurance companies and will credit any such collections received to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be assessed 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, to the dentist or his/her assignee at the time the services are rendered, or within five (5) days of billing if credit shall be extended. I agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable in information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection 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 allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any or prior 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 individuals with whom I authorize the dentist to discuss my dental care.

I certify that I answered all questions accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined therein.

X.

_____

CONSENT TO PROCEED

I authorize Dr._____ and/or such associates or assistants as she/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 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. Occasionally drops of local anesthetic may contact the eyes and facial tissue and cause temporary irritation.

I understand that part of dental treatment, including preventive 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 the completion treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding ones 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 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 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. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonal, may result in complications of non-healing of the jaw bones 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 standard dental preventive 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:_____ Date:_____

Signature:_____ Date:_____

(Patient, legal guardian or authorized agent of patient)

Witness:_____ Date:_____