Welcome

To better serve you, please fill out this form completely. If you have any questions, feel free to ask.

Highland Heights Dental-Craig T Smith, DMD

4046 Highland Dr #115
Salt Lake City, UT 84124
Phone - 801.277.1412 Fax – 801.278.7280

Patient Information

Name _____

Preferred Name _____ M / F

Address _____

City, State, Zip_____

Home # _____ Cell #_____

Work # _____ Ext _____

Birth Date _____/_____/_____ Age _____

Soc. Sec _____ Drivers Lic _____

□-Married □-Single □-Divorced □-Widowed

Employer _____

We can notify you by email of an upcoming appointment

Email _____

Responsible Party – if different from patient

Name _____

Preferred Name _____ M / F

Relationship to Patient _____

Address _____

City, State, Zip_____

Home # _____ Cell #_____

Work # _____ Ext _____

Birth Date _____/_____/_____ Age _____

Soc. Sec _____ Drivers Lic _____

□-Married □-Single □-Divorced □-Widowed

Employer _____

Email _____

Emergency Contact – Person other than someone living with you

_____ _____ _____ _____

Name Home # Cell # Relationship

How did you hear about us?

□ Internet □ Insurance □ Mailer □ BNI □ Utah Blaze □ Friend/Family _____ □ Other _____

Our office is happy to help you file your insurance to receive your dental benefits. Dental benefit plans vary from employer to employer. We will gladly assist you to understand your benefits. Yet you are ultimately responsible to know and understand the benefits offered by your insurance. By law, we are required to implement deductibles and co-payments by your insurance and do not have the power to make your plan pay. I agree to pay for the portion of my bill that is not covered by my insurance (if insured) when the service is rendered. A service charge of 1.5% per month (18% APR) interest will be charged on account balances which are not paid within ninety days. In case of default, I agree to pay reasonable costs for collection; 40% (forty percent) of unpaid balance, including arbitration and/or mediation costs, attorney fees, court costs, etc. I authorize the release of my financially viable information to any collection agency if default occurs. I grant permission to contact me through any of the provided sources to discuss matters relating to this form or my account. I have read this information here or in larger print available. I understand that there will be a $30.00 charge per hour for broken appointments. **We do reserve the right to assess a fee for appointments in which we have not been given a 48 hour notice of rescheduling or cancellation.** I certify that I have answered all the questions on all forms correctly. I herby agree to abide by the conditions outlined hereon.

X_____ _____

Signature of Patient or Guardian Date

Primary Insurance Information

Name of Insured _____ Birth Date _____/_____/_____ Soc. Sec. _____

Relationship to Patient _____ Employer _____

Insurance Company _____ Policy Holder ID #_____

Ins. Phone # _____ Group # _____

Secondary Insurance Information

Name of Insured _____ Birth Date _____/_____/_____ Soc. Sec. _____

Relationship to Patient _____ Employer _____

Insurance Company _____ Policy Holder ID #_____

Ins. Phone # _____ Group # _____

Patient Name _____ **Highland Heights Dental**

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. Please answer the following questions. Our intent is to provide you with the best possible dental services. We use high quality dental materials and techniques tested and approved by the American Dental Association. All our instruments used in the mouth are sterilized by vapor autoclave, under high pressure and temperature.

Dental Health

How long has it been since you have been to a dentist _____ When was your last set of full mouth x-rays? _____

Are you currently in pain? □Yes □No When does it hurt? □Cold □Heat □Sweets □Constantly

Are you happy with the appearance of your teeth? □Yes □No If not, why? _____

Have you had any complications or difficulties with previous dental work? _____

Please list any dental problems or concerns _____

_____

Medical History

If yes, please explain

Are you under a physician's care now? □ Yes □ No _____

Name of physician _____ Phone # _____

Have you suffered any injury to your jaw or face? □Yes □No _____

Have you taken Phen-Fen or Redux? □Yes □No _____

Please list any medications, pills or drugs currently taking and reasons _____

_____

Do you have or have you had any of the following:

□ Anaphylaxis	□ Diabetes	□ Heart Problems/Disease	□ Low Blood Pressure
□ Arthritis/Gout	□ Drug Addiction	□ Hemophilia	□ Mitral Valve Prolapse
□ Artificial Heart Valve	□ Epilepsy/Seizures	□ Hepatitis A, B or C	□ Radiation Treatments
□ Artificial Joints	□ Excessive Bleeding	□ High Blood Pressure	□ Rheumatic Fever
□ Asthma	□ Fainting Spells/Dizziness	□ HIV/AIDS	□ Sinus Trouble
□ Blood Disease	□ Frequent Headaches	□ Hypoglycemia	□ Stroke
□ Cancer/Chemotherapy	□ Heart Attack/Failure	□ Jaw Pain	□ Thyroid Disease
□ Chest Pains	□ Heart Murmur	□ Kidney Problems	□ Tobacco Habit
□ Cold Sores/Fever Blisters	□ Heart Pace Maker	□ Liver Disease	□ Tuberculosis

Any condition not listed above □Yes □No _____

Women: Are you pregnant □Yes □No Due date? _____ Nursing? □Yes □No Oral Contraceptives? □Yes □No

Allergies:

□ Acrylic	□ Codeine	□ Latex	□ Metals	□ Other _____
□ Aspirin	□ Erythromycin	□ Local Anesthetic	□ Penicillin/Amoxicillin	

AGREEMENT AND CONSENT TO PROCEED: I authorize Dr Craig T Smith DMD and or such assistants or associates 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 and other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide) analgesic, therapeutic or surgical treatments, and to select and use appropriate dental materials, and to take necessary x-rays.

I understand the administration of local anesthetics may cause and 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. Antibiotics may render oral contraceptives ineffective. I am aware that precautions should be taken if antibiotics are prescribed at the same time I am using birth control pills.

I understand there are possible risks with dental treatment and dental materials. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with the general and operative treatment procedure or medicines, in hope of obtaining the potential desired results, which may or may not be achieved, for 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 the opportunity to ask questions. I am aware that Dr. Smith does not do amalgam (mercury) fillings to restore teeth. I understand that if my insurance does not cover amalgam fillings, I am responsible to pay the difference. 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.

X _____ _____ _____

Signature of Patient or Responsible Party Print Name Date