AARON T. WARD DMD MS PC
Periodontics and Dental Implants

College Park Plaza • 3590 Harrison Blvd. Suite 3
Ogden, Utah 84403
Phone 801.394.6651 • Fax 801.394.2557

PATIENT HISTORY INFORMATION

Male ❑ Female ❑

Patient's Name _____ Date _____

Birthdate _____ Age _____ Social Security No. _____

Home Address _____ City/State/Zip _____ Phone _____

Email Address _____ Cell Phone _____

Employer _____ Occupation _____

Business Address _____ City/State/Zip _____ Phone _____

Marital Status: (Please Circle) Single Married Divorced Widowed Separated

Person Responsible for Account: (Complete Name) _____

Relationship _____ Social Security No. _____ DOB _____

Spouse's Name _____ Spouse's Social Security No. _____

Spouse's Employer _____ Spouse's Occupation _____ DOB _____

DENTAL HISTORY

Who is your regular Dentist? _____ How often do you see your dentist? _____

When did you last see him/her? _____ What was the purpose of your last visit? _____

Have you had any of the following?

Braces (Orthodontic treatment)? . . . . . Yes ❑ No ❑

Treatment for gum disease? . . . . . Yes ❑ No ❑

Pain and clicking of the jaws . . . . . Yes ❑ No ❑

Bleeding when brushing? . . . . . Yes ❑ No ❑

Dental implants? . . . . . Yes ❑ No ❑

Are you happy with your smile? . . . . . Yes ❑ No ❑

INSURANCE

Primary Carrier	Secondary Carrier
Dental Insurance Company _____	Dental Insurance Company _____
Address _____	Address _____
Insured Person _____	Insured Person _____
Birthdate _____	Birthdate _____
Employed by _____	Employed by _____
Soc. Sec. # _____	Soc. Sec. # _____
Aid or Group # _____	Aid or Group # _____

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. Pay the doctor at the time of treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 60 days from the date of first billing to pay 1.5% per month on the unpaid balance with a minimum of $1.00 per month.
3. I/We agree to pay all attorney's fees, court costs, filing fees, including charges or commissions that may be assessed to us by any collection agency retained to pursue this account should become delinquent.
4. That a credit report may be obtained if necessary.

Date: _____ Responsible Person: _____

Aaron T. Ward DMD, MS
Medical History

Patient Name (Print) _____

Pharmacy _____

Location _____

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 physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ○ Yes ○ No If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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:

X

Date:_____

Aaron T. Ward DMD MS PC

3590 Harrison Suite #3 Ogden Utah 84403

HIPPA CONSENT

I agree to permit my protected health information to be used and disclosed for purposes of treatment, payment, and health care operations. For more details about these uses and disclosures, I may request a copy of the HIPPA Privacy Notice.

Dr. Aaron T. Ward reserves the right to change the privacy policies described in the Privacy Notice. I may call to receive any updates to the Privacy Notice.

I have the right to request that I may restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Dr. Aaron T. Ward is not required to agree with this request, but if he does, he is bound by it.

I have the right to revoke my consent in writing. A revocation, however, will not apply to the extent Dr. Aaron T. Ward has taken action in reliance upon the use or disclosure of my information.

I agree to let Dr. Aaron T. Ward and staff to leave messages concerning appointments and/or account information on my answering machine and/or with a family member. If I give my cell number and Email, I may be contacted by these methods also.

I authorize Dr. Aaron T. Ward and staff to release any medical and/or account information to :

Name (print) _____Relation:_____

Phone: _____

Name (print): _____Relation:_____

Phone: _____

PATIENT NAME (print)_____Date:_____

SIGNATURE_____

UPDATE YEARLY

Initials:_____ Date:_____ Initials:_____ Date:_____

Initials:_____ Date:_____ Initials:_____ Date:_____