Aaron T. Ward
DMD MS PC
Periodontics and Dental Implants

College Park Plaza • 3590 Harrison Blvd. Suite 1
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Phone 801.394.6651 • Fax 801.340.9561

PATIENT INFORMATION

Male ☐ Female ☐
Patient's Name _____ Date _____
Birthdate _____ Age _____ Social Security No. _____
Home Address _____ City/State/Zip _____
Email Address _____ Cell Phone _____ Phone _____
Employer _____ Occupation _____
Martial 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 Secutrity No. _____
Spouse's Employer _____ Spouse's Occupation _____
How did you hear about our office? ☐Hometown Values ☐Dentist ☐Internet ☐Facebook ☐Friend

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 of gum disease? . . . . . Yes ☐ No☐
Pain and clicking of the jaws? . . . . . Yes ☐ No☐
Back Pain? . . . . . Yes ☐ No☐
Bleeding with brushing? . . . . . Yes ☐ No☐
Dental Implant? . . . . . Yes ☐ No☐
Are you happy with your smile? . . Yes ☐ No☐
Please explain _____

INSURANCE

Primary Carrier

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

Secondary Carrier

Dental Insurance Company _____
Address _____
Insured ID# _____
Insured Person _____
Birthdate _____
Employed by _____
Soc. Sec. # _____
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:
1. To pay the doctor at time of treatment or service, unless prior arrangements have been made.
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 minimun of $1.00 per month.
3. To pay all attorney's fees, court cost, filing fees, including charges of commissions that may be assessed to us by any collection agency retained to pursue this account should it become delinquent.
4. That a credit report may be obtained if necessary.
I understand that if my account should become delinquent a collection fee of 33.33% will be added to my balance when account is turned over to collections.
Date: _____ Responsible Person: _____

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 alergic to any of the following?

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

Other? ○Yes ○No

Do you use controlled substances? ○Yes ○No

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
Artifical 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/Intstinal 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 Peacemaker ○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 Guardian: _____

X _____ Date: _____

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HIPAA CONSENT

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

Aaron T Ward Periodontist and Dental Implants reserves the right to change the privacy policies described in the Privacy notice. I may call to receive any updated 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 Aaron T. Ward has taken action in reliance upon the use or disclosure of my information.

I agree to let Aaron T. Ward Periodontics 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 Aaron T. Ward and staff to release any medical and/or account information to:

Name (print)________________________________Relation___________________________

Phone______________________________

Name (print)________________________________Relation____________________________

Phone________________________________

Patient Name_______________________________Date_______________________________

SIGNATURE_________________________________

- -

UPDATE YEARLY

Initials:_____________**Date:**__________ **Initials:**_____________**Date:**__________

Initials:_____________**Date:**__________ **Initials:**_____________**Date:**__________