ARPD
Affleck Dental
Restoration & Prosthodontics
Michael S. Affleck, D.D.S.

466 N. Main, Suite 100
Clearfield, UT 84015

(801) 782-5010

Part I. Patient Information

Patient Name ________________________ Birth Date ________________________
Phone: Home ____________________ Cell ________________ Business ________________
Address ________________________ City ______________ State _____ Zip ________
Sex: M____ F____ Patient's Social Security # ______________ Marital Status: M _____ S____W____ D_____
Patient's Employer ____________________ Patient's Occupation ____________________
Spouse's Name ____________________ Spouse's Social Security # ____________________
Person to contact in case of emergency ____
Address ____________________ Phone # ______________ Relationship ____________
Email Address ________________________________

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of responsible party ________________________________ Relationship ____________
Residence Address ____________________ City, State ____________________ Zip ________
Home Phone # ____________________ Social Security # ____________________
Employer's Address ____________________ City, State ____________________ Zip ________
Business Phone # ____________________

Part II. Insurance and Address **(Use your insurance identification card)**

Name of insurance company ____________________ Group Number ____________________
Address ________________________________ Insurance Co. Tel # ____________________
Subscriber's Name ____________________ Subscriber's Social Security # ____________________
Your relation to subscriber ____________________ Subscriber Birth date ____________________
Subscriber's Employer ________________________________ Employer Phone # ____________
Is patient covered under more than one Dental Plan? ________________________________

FINANCIAL POLICY: As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment. This office will help prepare the insurance forms of our patients and assist in making collections from the insurance companies. The patient agrees to assign insurance benefits to be applied to unpaid balances. However, we cannot render service on the assumption that our charges will be paid by an insurance company. For unpaid accounts, a service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed to accounts exceeding sixty days from date of service unless previous written financial arrangements are satisfied. The patient or responsible party agrees to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed, including charges or commissions up to 50% that may be assessed to us by any collection agency retained to pursue this matter. The fee estimates for this dental care can only be extended for a period of six months from the date of patient examination.

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICIES:
By signing below I acknowledge that I have received a copy of this office's Privacy Policies.

CONSENT TO PROCEED: I authorize Dr. Michael S. Affleck and/or such associates or assistants as he may designate to preform 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. This may include arrangements 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 and 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 preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit. 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. I give permission for your office to submit insurance claims for services rendered.

I understand that the administration of local anesthetic may cause an unwanted reaction or side effects, which may include, but not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness.

Signature ________________________________ Date ____________________
Print Name Legibly ____

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HEALTH HISTORY

(Please Print)

Name ______________________ Age ________ Date of Birth ____________

DENTAL

1. Name of referring dentist or person ______________________
2. Are you having pain or discomfort at this time? ❑ Yes ❑ No
3. Do you have any present dental complaints (bleeding gums, loose teeth, unhappy with appearance, etc.)? ❑ Yes ❑ No
   If so, explain ______________________
4. Have you ever had an unusual reaction to dental anesthetic? ❑ Yes ❑ No
5. If you have or ever have had the following, check the box:
   - ❑ Cold or Canker sores
   - ❑ Sensitivity to biting or pressure
   - ❑ Sensitivity to hot, cold or sweets
   - ❑ Food trapped between teeth
   - ❑ Pain, clicking, or popping of jaw
   - ❑ Frequent headaches
   - ❑ Injury to face, jaw or teeth
   - ❑ Clenching or grinding teeth
   - ❑ Periodontal (gum) treatment
   - ❑ Orthodontic treatment (braces)
   - ❑ Chronic Snoring
   - ❑ Frequent day time sleepiness
6. If you or your family are interested in any of our additional services please check box:
   - ❑ Cosmetic Dentistry
   - ❑ Implant's
   - ❑ Crown/Bridge/Veneers
   - ❑ Dentures
   - ❑ Whitening
   - ❑ Cleanings
7. Any other dental condition not mentioned above: ______________________
8. Are you interested in, or have you considered, makeover procedures like cosmetic dentistry or plastic surgery? ❑ Yes ❑ No

MEDICAL

1. The name, address and phone number of my physician is ______________________
2. Are you currently under the active care of a physician for a specific condition? ❑ Yes ❑ No
   If so, what is the condition? ....
3. Has there been any change in your general health within the past year? ❑ Yes ❑ No
4. Have you had any serious illness within the past five (5) years? ❑ Yes ❑ No
   If so, what was/is the illness? ....
5. Have you been hospitalized or had an operation within the past five (5) years? ❑ Yes ❑ No
   If so, what was the reason? ....
6. Do you have or have you ever had any of the following diseases or problems:
   a. Rheumatic Fever or Rheumatic Heart Disease ❑ Yes ❑ No
   b. Heart Disease (Artificial Heart Valves, Endocarditis, Congenital heart malformations, Mitral valve prolapse with valvular regurgitation, cardiomyopathy) ❑ Yes ❑ No
   c. Cardiovascular Disease (Heart Attack, Coronary Insufficiency, Coronary Occlusion, High Blood Pressure, Arteriosclerosis, Stroke, etc.) ❑ Yes ❑ No
   d. Hepatitis (any type) ❑ Yes ❑ No
   e. Jaundice, Cirrhosis or Liver Disease ❑ Yes ❑ No
   f. Tuberculosis, Bronchitis or Emphysema ❑ Yes ❑ No
   g. Sinus Trouble, Asthma or Hayfever ❑ Yes ❑ No

(please continue on other side)

7. (continued) Do you have or have you ever had any of the following diseases or problems:

- h. Severe Headaches, Earaches or Loss of Hearing Hives or Skin Rash ❑ Yes ❑ No
- j. Fainting Spells, Seizures or Convulsions ❑ Yes ❑ No
- k. Diabetes ❑ Yes ❑ No
- l. Arthritis or Inflammatory Rheumatism ❑ Yes ❑ No
- m. Artificial or Prosthetic Joint Replacement ❑ Yes ❑ No
- n. Ulcers, Gastritis, Colitis or other Stomach or Intestinal Conditions ❑ Yes ❑ No
- o. Kidney or Bladder Troubles ❑ Yes ❑ No
- p. Organ Transplant (kidney, heart, etc.) ❑ Yes ❑ No
- q. Immune System Disorders (AIDS, HIV, or ARC) ❑ Yes ❑ No
- r. Sexually Transmitted Disease (Venereal Disease) ❑ Yes ❑ No
- s. Glaucoma, Cataracts ❑ Yes ❑ No
- t. Other ❑ Yes ❑ No

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ❑ Yes ❑ No

9. Do you have any blood disorder such as anemia, leukemia or sickle cell anemia? ❑ Yes ❑ No

10. Have you had surgery or radiation treatment for a tumor, growth or other condition? ❑ Yes ❑ No

11. List any medications (prescription and over-the-counter, such as aspirin or vitamins) that you are now taking or have taken within the past 6 months. Include everything: Antibiotics, Anticoagulants (Blood Thinners), High Blood Pressure Medicine, Cortisone (Steroids), Tranquilizers or Antidepressants, Antihistamines, Insulin or other Diabetic Medications, Digitalis or other Heart Medications, Nitroglycerine, etc.:

____

____

12. Are you allergic to or have you ever reacted adversely to any medications? ❑ Yes ❑ No

If so, list them: ____

13. Do you use or have you used street drugs? ❑ Yes ❑ No

14. Do you use tobacco in any form? ❑ Yes ❑ No

15. Do you use any alcohol products? ❑ Yes ❑ No

16. Are you engaged in any situation which exposes you to x-rays or other ionizing radiation? ❑ Yes ❑ No

17. Women - Are you pregnant or do you have any reason to think you may be pregnant? ❑ Yes ❑ No

18. Women - Are you taking birth control pills or hormone therapy? ❑ Yes ❑ No

19. Do you have any disease, condition or problem not listed above? ❑ Yes ❑ No

If so, explain ____

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify he dentist of any changes at any subsequent appointment.

Signature ______________________________________ Date ____________

HEALTH HISTORY UPDATES

Date ________________ Change(s) ❑Yes ❑No ______________________

Date ________________ Change(s) ❑Yes ❑No ______________________

Date ________________ Change(s) ❑Yes ❑No ______________________

Date ________________ Change(s) ❑Yes ❑No ______________________

Date ________________ Change(s) ❑Yes ❑No ______________________

Date ________________ Change(s) ❑Yes ❑No ______________________

Date ________________ Change(s) ❑Yes ❑No ______________________

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SUMMARY OF PRIVACY PRACTICES

This summary contains condensed version of our **Office Privacy Practices.** Our full length notice is made available upon request by a patient.

We understand that your dental health information is personal to you and we are committed to protecting this information.

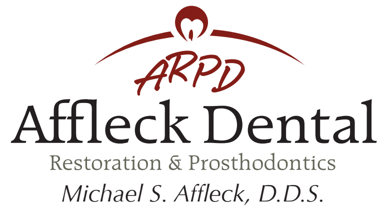
How we will use or disclose your information. Here are a few examples.

- For dental or medical treatment.
- To obtain payment for our services.
- Filing with your insurance company.
- Your authorization.
- Persons involved in care.
- In emergency situations
- to alert a serious threat to health or safety.
- For appointment and patient reminders.
- For worker' compensation programs.
- To operate our practice effectively and ensure all patients receive quality care.
- Subpeona or if required by law.

You have the right to read over or obtain copies of your dental health information. Copies may be made for a nominal fee.

If you believe your privacy rights have been violated you may submit a complaint to our privacy officer in writing or to the U.S. Dept. of Health & Human Services.

PLEASE KEEP THIS COPY FOR YOUR RECORDS



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ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICIES

I, ____, have received a copy of this office's Privacy Policies.

____
Name (Please Print Legibly)

____
Signature

____
Date