

 Stephen W. Pratt, DDS

Thank you for selecting us to provide for your oral health needs. We promise our best in providing you with Excellence, Value, and Care in dentistry and hope to become an office that you love and will refer your family and friends to.

**Patient Information**

Full Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Preferred Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Social Security#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Employer:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work Phone#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Cell Phone#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Male\_\_\_ Female\_\_\_

Married\_\_\_Single\_\_\_Child\_\_\_Widowed\_\_\_ Divorced \_\_\_ **Referral Source:** *(who can we thank for bringing you here?)\_\_\_\_\_\_\_***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Household Information** *(You only need to complete this section once per family)*

Home Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** State:**\_\_\_\_\_\_\_** Zip code:**\_\_\_\_\_\_\_\_\_\_\_** Home Phone#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Information** *(Make sure we make a copy of your* ***primary*** *and* ***secondary insurance*** *cards)*

*Primary Dental Carrier*

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB\_\_\_\_\_\_\_\_\_\_\_

Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Secondary Dental Carrier*

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB\_\_\_\_\_\_\_\_\_\_\_

Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Policies**

**Privacy Policy:** We are committed to keeping all of your information private and will not discuss or sharepersonal information except with those authorized by you. We shred and properly dispose of all documents that have any personal information on them. Your email is kept private. We fully comply with all provisions of HIPAA *(Health Insurance Portability & Accountability Act of 1996)*.We commit to informing you about all procedures. We encourage you to diligently ask us if you have any questions about any procedures or their necessity, for we want you completely comfortable throughout the entire process.

**Payment Policy**

· You agree to be responsible for payment of your own dental bill. We will do our best to help bill your insurance, but you are responsible if they do not cover services performed.

· **All copayments** *(or entire fee for customers without insurance)* **are due the day of your appointment.**

· We accept cash, checks, and credit cards.

· We offer **0% interest for up to 6 months** financing through **Care Credit**.

· **We charge $50 for all missed appointments without 24 hour cancellation notice, or if your appointment is canceled at the time of service because of your inability to pay or arrange financing.**

 **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health History**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician's name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician's Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes/ No**

**\_\_\_ \_\_\_**1. Have you been under a physician's care or had any health problems in recent years?

 If yes, please explain:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ \_\_\_**2. Please list **name** and **purpose** of any **medications** you currently take: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ \_\_\_**3. Are you currently taking a blood thinner? (type) \_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ \_\_\_**4. Do you require antibiotic premedication? (why/when?)\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_ \_\_\_**5. Please circle any **allergies:**  Latex Penicillin Other Antibiotics Sulfa Drug Local Anesthetic

 Other (*explain*)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ \_\_\_**6. (*Women only*) Are you pregnant, trying to get pregnant, or nursing? (*Which/Due Date?*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_7. Do you have a history of gum disease?

When was your last dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have or have you ever had any of the following?**

**Yes/No**

\_\_\_ \_\_\_Abnormal Bleeding

\_\_\_ \_\_\_Alcohol Abuse

\_\_\_ \_\_\_Allergies

\_\_\_ \_\_\_Anemia

\_\_\_ \_\_\_Angina/Chest Pain

\_\_\_ \_\_\_Arthritis

\_\_\_ \_\_\_Asthma

 (*last attack*?)\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Blood Transfusion

 (*when?*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Cancer

 (*type?*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Chemotherapy

\_\_\_ \_\_\_Colitis

\_\_\_ \_\_\_Congenital Heart Defect

 (*type?*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Diabetes (*type?*)\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Difficulty Breathing

\_\_\_ \_\_\_Drug Abuse

\_\_\_ \_\_\_Emphysema

\_\_\_ \_\_\_Epilepsy

**Yes/No**

\_\_\_ \_\_\_Facial Surgery

\_\_\_ \_\_\_Fainting Spells

\_\_\_ \_\_\_Fever Blisters

\_\_\_ \_\_\_Frequent Headaches

\_\_\_ \_\_\_Glaucoma

\_\_\_ \_\_\_HIV or AIDS

\_\_\_ \_\_\_Heart Attack

 (*when?*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Heart Conditions

 (*when/type?*)\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Heart Murmur

\_\_\_ \_\_\_Heart Surgery

 (*when/type?*)\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Hemophilia

\_\_\_ \_\_\_Hepatitis A, B, or C

*(type*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_High Blood Pressure

\_\_\_ \_\_\_Joint Replacement

 (*where/when?*)\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Kidney Problems

\_\_\_ \_\_\_Liver Disease

**Yes/No**

\_\_\_ \_\_\_Osteoporosis

\_\_\_ \_\_\_Pace Maker

\_\_\_ \_\_\_Psychiatric Problems

\_\_\_ \_\_\_Radiation Therapy

 (*when?*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Rheumatic Fever

\_\_\_ \_\_\_Seizures

 (*most recent?*)\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Sexually Transmitted Disease

\_\_\_ \_\_\_Sickle Cell Disease

\_\_\_ \_\_\_Sinus Problems

\_\_\_ \_\_\_Sleep problems (Apnea)

\_\_\_ \_\_\_Stroke

 (*when?*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Thyroid Problems

\_\_\_ \_\_\_Tuberculosis

\_\_\_ \_\_\_Ulcers

\_\_\_ \_\_\_Do you require Antibiotic Premedication?

\_\_\_ \_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following surgery or tooth extractions.

I hereby certify that my answers to the forgoing questions are accurate. Since a change in my medical conditions or medications can affect dental treatment, I agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

 **Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Patient, legal guardian or authorized agent of patient)*





***Did you know?*** We offer great promotions and give-a-ways on our Facebook page. We invite new patients to “like” our page – to be entered to win in our monthly drawing. You can also “check in” on Facebook at subsequent visits to our office to be entered again. Scan QR code for our Facebook page.

**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. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable and 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 at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient 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 insurance companies and will credit any such collections received to the patient account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A late charge of $25.00 will be assessed on all outstanding balances exceeding thirty days from the date of service unless previously written financial arrangements with a secured credit/debit card on file. Additional $25.00 late fees will follow if account balance exceeds 60 days. I understand that treatment plan estimates that have been provided to me for my dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to Dr. Stephen W. Pratt or his assignee at the time said 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 in accordance with Utah Code Annotated, sec12-1-11. I authorize the release of financially identifiable 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 work place to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my machine or with a family member. I also agree to allow this office to send promotions or specials via email, text, mail or phone. I understand the office will notify me by text, email or phone calls unless I have stated not to receive a particular reminder here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined hereon.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient, parent or guardian Date Relationship to patient

CONSENT TO PROCEED

I authorize Dr. Stephen Pratt, and/or such associates or assistants 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 or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesics, 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 tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. 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 as a part of the 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 the ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following 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 general preventative 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Please Print)

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Patient, legal guardian or authorized agent of patient)

**Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**