RIVER CITY DENTAL •2364 W. 12600 S. RIVERTON, UT 84065 • DR. KEVIN YEAGER, D.D.S. • 801-446-5050

PATIENT INFORMATION

STEP 1: PLEASE START HERE

TODAY'S DATE ______ NAME ______ ADDRESS ______ CITY ______ STATE ______ ZIP ______

BIRTH DATE ______ AGE ______ SS NUMBER ______ DRIVER'S LICENSE NUMBER ______

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ CHILD

EMAIL ADDRESS ______ HOME PHONE ______ WORK PHONE ______ CELL NUMBER ______ FAX NUMBER ______ SCHOOL (IF APPLICABLE) ______

STEP 2: INSURANCE INFORMATION

INSURANCE COMPANY ______ ADDRESS ______ INSURANCE PHONE NUMBER ______

GROUP NUMBER ______ SUB ID NUMBER ______ INSURED EMPLOYEE NAME ______ BIRTH DATE ______ EMPLOYEE SS NUMBER ______ DATE EMPLOYED ______

STEP 3: PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME ______ ADDRESS ______ CITY ______ STATE ______ ZIP ______

SS NUMBER ______ DRIVER'S LICENSE NUMBER ______ HOME PHONE ______

EMPLOYER ______ WORK NUMBER ______ WORK ADDRESS ______ CITY ______ STATE ______ ZIP ______

SPOUSE'S NAME ______ SS NUMBER ______ DRIVER'S LICENSE NUMBER ______

EMPLOYER ______ WORK NUMBER ______ WORK ADDRESS ______ CITY ______ STATE ______ ZIP ______

STEP 4: EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT ______ ADDRESS ______ CITY ______ STATE ______ ZIP ______ HOME PHONE ______ WORK PHONE ______

RELATIVE NOT LIVING WITH YOU ______ ADDRESS ______ CITY ______ STATE ______ ZIP ______ HOME PHONE ______ WORK PHONE ______

STEP 5: PLEASE READ AND SIGN

OFFICE POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments *(the amount not covered by insurance)* are due and payable at the time of service. There will be a fee assessed for missed appointments.

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's account. However, this dental office cannot render services or the assumption that our charges will be paid in full by an insurance company.

A service charge of a 1.5% per month *(18% per annum)* on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for 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, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended, I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions *(up to 50% of principle)* that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Kevin Yeager.

I certify that I have answered all questions on the form accurately and I hereby agree to abide by the conditions outlined there in.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE	RELATIONSHIP TO PATIENT

How did you hear about us? ______________________

Did someone refer you? (If so, we want to thank them)

NAME	ADDRESS	CITY	STATE	ZIP

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MEDICAL INFORMATION

STEP 1: PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS

Yes No

❑ ❑ 1. Are you having pain or discomfort at this time?
❑ ❑ 2. Do you feel nervous about having dental treatment?
❑ ❑ 3. Have you been hospitalized during the past two years?
❑ ❑ 4. Have you been under the care of a medical doctor during the past two years?
Physician's Name ______________________ Type of Practice ______________________
Address ______________________ Phone ______________________
❑ ❑ 5. Have you taken any medication or drugs during the past two years?
❑ ❑ Are you now taking any medication, drugs or pills?
If yes, please list: ______________________
❑ ❑ 6. Are you allergic or have you reacted adversely to any of the following medications?

❑ Aspirin
❑ Darvon
❑ Codeine
❑ Demerol
❑ Nitrous Oxide
❑ Erythromycin
❑ Tetracycline
❑ Percodan
❑ Valium
❑ Scopolamine
❑ Penicillin
❑ Other Antibiotics
❑ Local Anesthetic (Novocaine or Xylocaine)
❑ Sleeping Pills (Nembutal/Seconal)

7. Check any of the following, which you have had or have at present:

❑ Heart Failure
❑ Heart Disease or Attack
❑ Angina Pectoris
❑ High Blood Pressure
❑ Heart Murmur
❑ Rheumatic Fever
❑ Congenital Heart Lesions
❑ Scarlet Fever
❑ Heart Pacemaker
❑ Heart Surgery
❑ Artificial Joints (Knee, Hip)
❑ Anemia
❑ Stroke
❑ Kidney Trouble
❑ Ulcers
❑ Cosmetic Surgery
❑ Drug Addiction
❑ Emphysema
❑ Cough
❑ Tuberculosis (TB)
❑ Asthma
❑ Hay Fever
❑ Sinus Trouble
❑ Allergies or Hives
❑ Diabetes
❑ Thyroid
❑ X-ray or COBALT Treatment
❑ Chemotherapy (Cancer, Leukemia)
❑ Arthritis
❑ Rheumatism
❑ Cortisone Medicine
❑ Glaucoma
❑ Pain in Jaw Joints
❑ Cold Sores
❑ A.I.D.S. or H.I.V.
❑ Hepatitis A (infectious)
❑ Hepatitis B (serum)
❑ Hepatitis C
❑ Liver Disease
❑ Yellow Jaundice
❑ Blood Transfusion
❑ Hemophilia
❑ Fever Blisters
❑ Epilepsy or Seizures
❑ Fainting or Dizzy Spells
❑ Nervousness
❑ Psychiatric Treatment
❑ Sickle Cell Disease
❑ Bruise Easily
❑ Other ______________________
❑ Other ______________________

❑ ❑ 8. When you walk up stairs or take a walk, do you ever have to stop because of pain in the chest, shortness of breath, or because you are very tired?
❑ ❑ 9. Do your ankles swell during the day?
❑ ❑ 10. Do you use more than 2 pillows to sleep?
❑ ❑ 11. Are you on a special diet? If so, please explain. ______________________
❑ ❑ 12. Do you have any disease, condition, or problem not listed? ______________________
❑ ❑ 13. Have you visited a dentist in the past year? Date of last dental visit: ______________________
❑ ❑ 14. Do you use tobacco products?
15. FOR WOMEN ONLY:
❑ ❑ ARE YOU PREGNANT?
If yes, what month? ______________________
❑ ❑ Are you taking birth control pills?

I hereby certify that the answers to the above questions are accurate to the best of my knowledge.

______________________ ______________________ ______________________
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE RELATIONSHIP TO PATIENT

STEP 2: REVIEW OF MEDICAL HISTORY

I have reviewed the foregoing Medical History (other side) and find it to be unchanged and accurate, except as noted.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE	UPDATE
SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE	UPDATE
SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE	UPDATE

STEP 3: PLEASE READ AND SIGN

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

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 medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Kevin Yeager 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), analgesic, 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, temporary or permanent numbness, and muscle soreness.

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 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 as necessary and I have been given the opportunity to ask questions.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE	RELATIONSHIP TO PATIENT

STEP 4: PLEASE READ AND SIGN

MEDIATION AGREEMENT

Should any claim or controversy arise between the patient and/or a legally authorized representative of the patient and dentist concerning the care and treatment rendered by the dentist to the patient, an effort shall be made by the parties involved to resolve the dispute through the mediation according to the rules of WESTERN MEDIATION, should the dispute pertain to the quality of the dental services rendered. Thus, a claim or controversy shall first be submitted to non-binding mediation. Costs for the mediation services shall be shared equally by the parties involved. The foregoing mediation agreement does not pertain to actions taken for the collection of debts owed as a result of dental services rendered.

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