

R. Bruce Howell, DDS, MS, BS
Pediatric Dentistry
442 W. 800 N.
Orem, Utah 84057

Date _____

PATIENT INFORMATION

Name _____ Nickname _____ Male
last first m Female

Address _____
street apt # city state zip

Birth Date _____ Home Phone _____
month day year

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

Parent/Responsible Party _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthday _____ Soc. Sec. Number _____ Insurance: Primary Secondary

Employer _____ Dental Insurance _____ Medical Insurance _____

Dental Insurance ID _____ Medical Insurance ID _____

Additional Parent or Guardian _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthday _____ Soc. Sec. Number _____ Insurance: Primary Secondary

Employer _____ Dental Insurance _____ Medical Insurance _____

Dental Insurance ID _____ Medical Insurance ID _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Address _____

Phone _____

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with Federal Truth-in-Lending Act please be advised of the following office policies in connection with the extension of credit. By signing this agreement, the responsible party agrees to:

- 1) Pay in full each time services are rendered. We accept cash, check or Visa, Discover and Mastercard.
- 2) Pay a late fee on any unpaid balance when payment is not received by due date listed on mailed statements.
- 3) Authorize a credit report to be obtained if necessary.
- 4) Your insurance is ultimately a contact between you, your employer and the insurance company. We will assist you in filing your claim but the final responsibility for payment rests with you.

I agree to pay the remaining balance plus all collection/court costs and fees (a minimum of 50%) if a delinquent balance is placed with a collection agency or attorney.

Date _____

MEDICAL INFORMATION
PLEASE RESPOND TO EVERY QUESTION

1. Does your child have any history of health problems from birth or early years?

2. Is your child taking any medications at this time? YES NO
If so, what medications? _____
3. Has your child ever had a reaction to penicillin or other drugs? YES NO
If so, what drug(s)? _____
4. Does your child have any allergies? _____
5. Is your child presently under treatment for any medical condition? YES NO
If so, what condition? _____
6. Has your child ever had a history of the following: (circle)

allergies	rheumatic fever	cancer/leukemia	asthma
mental retardation	hay fever	tuberculosis	stroke
liver disease	mental/emotional problems	blood disorder	hepatitis
heart problems	breathing problems	earaches	anemia
heart murmur	endocrine problems	headaches	HIV/AIDS
sinusitis	tonsil/adenoid problems	cerebral palsy	pregnancy
epilepsy	kidney/bladder problems	arthritis	venereal disease
brain damage	diabetes	abnormal bruising	other _____
7. Has your child ever had an unfavorable experience in a dental or medical office? YES NO
8. Has your child had a toothache recently? YES NO
9. Date and place of last dental exam _____
10. Is your child required to take antibiotic premedication? YES NO
11. Does your child have a history of thumbsucking, lip or nail biting? YES NO
12. Has your child had any teeth extracted? YES NO
13. Has your child ever been on a respirator? YES NO
14. How is the general health of parents and siblings? _____

I hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical condition or in medications I take can affect dental treatment, I understand the importance of and agree to take responsibility to notify the dentist of any changes at any subsequent appointment.

Date _____

Updated _____

CONSENT FOR DENTAL TREATMENT

I understand the above information is correct and necessary to provide my child with dental care in a safe and efficient manner. I request and consent to all procedures which my child's dental condition may require, including administration of any sedative, analgesic, therapeutic and/or other pharmaceutical agents including those related to restorative, palliative, therapeutic or surgical treatments. I understand that procedures in dental surgery, diagnosis and treatment are not an exact science and no guarantees as to the outcome of his/her treatments will be offered. I understand that as a part of dental treatment teeth may remain sensitive or even painful during and after completion of treatment. Jaw muscles may also be sore and tender. Gums and surrounding tissues may also be sensitive. Although rare it is possible for the tongue, cheek and oral tissues to be inadvertently abraded or lacerated during routine dental procedures. In some cases sutures or additional treatment may be required. I also understand that as part of dental treatment, in rare cases, small instruments or components may be aspirated or swallowed. This unusual situation may require x-rays and other procedures to ensure safe removal. Adverse reaction to materials, medicines, anesthetics and procedures are possible in dentistry possibly resulting in, but not limited to pulpal irritation, root canal treatment, loss of teeth, necrosis, infection, pain, anaphylactic shock and intestinal or systemic upset, and I voluntarily assume the possible risks. I accept Dr. Howell as my child's dentist and understand he will exercise all his professional knowledge to the best of his ability.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

Dr. R. Bruce Howell,
D.D.S., M.S.
442 W. 800 N.
Orem, UT 84097
(801) 802-7200

Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and a late fee of \$15 will be applied if not paid by the due date listed on the statement.

Payments: Payment is to be made at time of service, including insurance co-pays and out of pocket portions. If you have insurance we will prepare and submit insurance forms as a courtesy but you are responsible for payment of all dental services. We offer extended payment plans through Unicorn Financial.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned checks: Returned checks are automatically sent to Bonneville Collections with a returned check fee of \$25.

Appointment Scheduling: \$50.00 deposit required to schedule treatment. If less than 24 hours notice of cancellation, we have the option to keep the deposit.

Missed appointment fee: Patients who do not show up for an appointment, or cancel with less than 24 hours notice will be charged a \$35 fee. This fee must be paid before a new appointment is scheduled.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay an additional collection cost of 50%.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Contact information: You give us permission to telephone you at home or at your workplace to discuss matters related to this form. You also agree to let this office leave messages concerning appointments and/or results on your answering machine or with a family member.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature:

Date: