CHASE JUDD DDS
FAMILY & COSMETIC DENTISTRY

801-571-6688 **11760 South 700 East, Suite #110, Draper, UT 84020** **Draperdentalcare.com**

Patient name:_____ ☐ Male ☐ Female

Date of birth:_____ Social security #:_____-_____-_____ ☐ Married ☐ Single ☐ Minor

Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Telephone numbers: Home:_____ Work:_____ Cell:_____

Email address:_____ Best way to contact you:_____

Legal guardian name (if patient is under 18):_____

Person to contact in case of emergency:

Name:_____ Phone:_____

How did you hear about our office?

Friend/Relative (name):_____

- ☐ Insurance list
- ☐ Google
- ☐ Facebook
- ☐ Instagram
- ☐ Sign
- ☐ Mailer
- ☐ Web
- ☐ Other (please specify) _____

What services are you interested in?: (check all that apply)

- ☐ Replace silver fillings
- ☐ Having a whiter smile
- ☐ Smile makeover
- ☐ Invisalign
- ☐ Replace a missing tooth
- ☐ Other (please specify) _____

CONSENT TO PROCEED: I authorize Dr. Chase Judd, DDS, PLLC and/or such associates or assistants as s/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, 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 preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also 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 part of 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 to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. 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 jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental 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 if necessary and I have been given the opportunity to ask questions.

_____ I have received a copy, or have been offered and declined a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of patient, legal guardian or authorized agent Date

_____ _____

Witness Date

CHASE JUDD DDS
FAMILY & COSMETIC DENTISTRY

FINANCIAL INFORMATION AND POLICIES

Person responsible for this account_____

Address_____ Phone#_____

Is patient covered by dental insurance? ☐ Yes or ☐ No

Insurance Company Name_____

Address_____City/State/Zip_____

Telephone#_____

Whose name is the policy under? _____ Group#_____

Date of Birth_____ Social Security#_____-_____-_____

Employer Name_____ Employer Telephone#_____

Is patient covered by secondary insurance? ☐ Yes or ☐ No

Insurance company name_____

Address_____ City/State/Zip_____

Telephone#_____

Whose name is the policy under?_____ Group#_____

Date of Birth_____ Social Security#_____-_____-_____

Employer Name_____ Employer Telephone#_____

AUTHORIZATION AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to Chase Judd, DDS, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurances. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

AGREEMENT OF FINANCIAL RESPONSIBILITY:

1. The responsible party agrees to pay the doctor at the time treatment or services is received or by previous arrangements. In accordance with the Federal Truth-In-Lending Act, which requires all doctors to give their patients information in connection with extension of credit, such as when insurance payment is pending, please
2. The responsible party agrees:
   A. That if payments are extended beyond 30 days from the date of first billing, to pay 1.5% per month on the unpaid balance (annual rate of 18%) with a minimum charge of $1.00 per month. Interest not paid when due shall be added to and become part of the principal.
   B. To pay all attorney fees and costs, all legal fees, and collection fee of $75.00 or 30%, whichever is greater, should this balance become delinquent and be placed with an agency for collection or be taken to small claims or circuit court.
   C. That even though I have some type of insurance coverage, I am responsible for payment of services.Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated.
3. Permission is given to obtain a credit report if credit is applied for.
4. I understand that there is a $35.00 fee for missed appointments with less than 24-hour notice.

_____ _____

Signature of patient, legal guardian or authorized agent Date

PATIENT HEALTH INFORMATION

Date:_____

Patient Name:_____ DOB: _____ Current Dental Health: Good / Fair / Poor

Physician's Name:_____ Phone:_____ Current Physical Health: Good / Fair/ Poor

Under Physician's care in last 12 months? Y / N If Yes, please describe:_____

Current Prescription Medications:_____

Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? Y /N

Please indicate if you are currently taking or in the past have taken any of the following:

- ☐ Phen-Fen or similar
- ☐ Fosamax, Boniva, Bisphosphonates
- ☐ Tobacco, if yes then frequency:_____
- ☐ Alcohol: if yes then frequency:_____

Have you ever received counseling for use of alcohol or prescription drugs? Y / N

Have you ever had a nervous breakdown or received psychiatric treatment? Y / N

FOR WOMEN ONLY

Are you taking birth control pills? Y /N

Are you pregnant or trying to get pregnant? Y / N

If Yes, Due Date:_____

Are you nursing? Y / N

DENTAL HISTORY

Previous Dentist:_____

Last Dental Visit? _____

Are you currently in pain? Y / N

Do you like your smile? Y / N

Do you have bleeding or sensitive gums? Y /N

MEDICAL HISTORY Circle Yes (Y) or No (N) for each item below:

Y / N Abnormal Bleeding
Y / N AIDS/HIV
Y / N Anemia
Y / N Angina Pectoris
Y / N Arthritis
Y / N Artificial Heart Valve
Y / N Artificial Joint
Y / N Asthma
Y / N Blood Transfusion
Y / N Bruise Easily
Y / N Cancer:_____
Y / N Canker Sores
Y / N Chemotherapy
Y / N Cold Sores
Y / N Congenital Heart Failure
Y / N Dental Anxiety
Y / N Diabetes
Y / N Drug Addiction
Y / N Emphysema
Y / N Epilepsy
Y / N Eye Surgery
Y / N Fainting / Dizzy Spells
Y / N Freq / Severe Headaches
Y / N Frequent Chest Pain
Y / N Glaucoma
Y / N Hay Fever
Y / N Heart Disease
Y / N Heart Murmur
Y / N Hemophilia
Y / N Hepatitis A / B / C
Y / N High Blood Pressure
Y / N Implant Prosthesis
Y / N Jaundice
Y / N Kidney Disease
Y / N Liver Disease
Y / N Mental Disorder
Y / N Multiple Sclerosis
Y / N Osteoporosis
Y / N Pacemaker
Y / N Periodontal Disease
Y / N Radiation Therapy
Y / N Rheumatic Fever Positive
Y / N Seizures
Y / N Shingles
Y / N Shortness of Breath
Y / N Sinus Problems
Y / N Stroke
Y / N Swollen Ankles
Y / N Thyroid Disorder
Y / N Tuberculosis
Y / N Ulcer
Y / N Unexplained Weight Loss
Y / N Venereal Disease
Other:_____

ALLERGIES (Circle all that apply)

- ☐ Acetaminophen
- ☐ Acrylic
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metal
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other:_____

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

Patient, Legal Guardian or Authorized Agent Signature:_____ Date:_____

Doctor Signature: _____ Date:_____

Updated Medical History: Date/ Initial:_____ Date/ Initial:_____ Date/ Initial:_____