Welcome to the APEX Family!

Riverton | Sandy | Draper | Murray | Stansbury Park | Clearfield

PATIENT INFORMATION

Date: _____

Full Name:_____Preferred Name:_____DOB:_____

SSN:_____Sex: M / F Email: _____

Home Address:_____Apt #_____

City:_____State:_____Zip: _____

Home Phone:_____Cell Phone:_____Work Phone:_____

Drivers License Number:_____State:_____Exp. Date:_____Marital Status: M / S / W / D

Employer:_____Yrs Employed:_____Occupation: _____

Spouse Full Name:_____SSN:_____DOB:_____

Employer:_____Yrs Employed:_____Occupation: _____

Emerg. Contact Name:_____Relationship: _____Emerg Contact Phone: _____

Has Patient been seen at another Apex Location? Y / N If yes, which office? _____

Are you happy with your smile? Y/N If no, what would you like to change?_____

How did you hear about us? ☐ Family or friend:_____ ☐ Internet ☐ Facebook ☐ Insurance

☐ Radio (97.1 ZHT) ☐ Radio (105.7 KNRS) ☐ Radio (106.7 ROCK) ☐ Radio (96.3 X96) ☐ Radio (Other)

☐ TV (CBS Channel 2) ☐ TV (ABC Channel 4) ☐ TV (Other) ☐ Location/Walk-In ☐ Other:_____

RESPONSIBLE PARTY INFORMATION (if different from Patient)

Responsible Party Name:_____Relationship to Patient: _____

DOB:_____SSN:_____Email:_____

Address:_____Apt#_____City:_____State:_____Zip: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

Employer:_____Yrs Employed:_____Occupation: _____

DENTAL INSURANCE INFORMATION (if applicable)

Name of Insured:_____ Relationship to Patient: _____

DOB:_____ SSN:_____ Employer: _____

Primary Insurance Co. Name:_____ Insurance Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

Insurance Member ID:_____ Group #:_____ Ortho Coverage: Y / N

Do you have Secondary Insurance? Y/N

Name of Insured:_____ Relationship to Patient: _____

DOB:_____ SSN:_____ Employer: _____

Secondary Insurance Co. Name:_____ Insurance Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

Insurance Member ID:_____ Group #:_____ Ortho Coverage: Y / N

Do you have medical insurance? Y/N

Name of Insured:_____ Relationship to Patient: _____

DOB:_____ SSN:_____ Employer: _____

Medical Insurance Co. Name:_____ Insurance Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

Insurance Member ID:_____ Group #:_____ Ortho Coverage: Y / N

OFFICE USE ONLY

Copy of Dental Insurance Card(s) ☐ Copy of Responsible Party Driver's License ☐ Copy of Medical Insurance Card ☐

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

Have you ever taken Phen-Fen or similar appetite suppressant? Y/ N If Yes, have you since had a cardiac evaluation? Y/ N

Have you ever taken Fosamax, Boniva or any drugs to decrease bone resorption or drugs for metastatic bone cancer? Y / N

Have you ever used or are now using tobacco? Y / N or alcohol? Y / N 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? 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 Positive
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
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 Barbiturates Dental Anesthetics Latex Sulfa
Aspirin Codeine Erythromycin Penicillin 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: _____

FINANCIAL AGREEMENT

We, the staff of Apex Dental & Orthodontics, thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest quality care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities; please feel free to contact us at 801-566-8833.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider/patient relationship. If you do not have insurance, proof of insurance, or you participate in a plan that will not honor an assignment of insurance benefits, payment in full for services will be due at the time of service. We ask that you realize that we do not work for an insurance company. Rather, we work 100% for you our patient. We feel that insurance can be a great benefit for many patients, and want you to know we will work on your behalf with your insurance provider to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

We accept many forms of payment for your convenience such as (cash, money order, MasterCard, Visa, Discover, American Express, in-state checks, and Care Credit). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest
I understand and agree that any unpaid balance over thirty (30) days will be charged an interest fee of 18% annually

Collections
I agree to be financially responsible for all procedures I elect to have performed. I understand and agree that all fees are required to be paid in full at time of service. I understand and agree that should my account require outside collection efforts, all court costs and attorney fees, plus a collection fee of up to 33.3% or the maximum allowed by Utah law will be added to my account.

Insurance
Please remember that your insurance is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment for services from their insurance carrier. We do ask patients to be interactive in communicating with your insurance carrier as well as our office on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. We do our best to verify benefit levels prior to services being rendered and to provide accurate cost estimates but it is not a guarantee of payment. Even a pre-authorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.
Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier. It is ultimately the patient's responsibility to know if our office is participating or non-participating with your specific insurance policy.

We will provide all necessary information to have your benefits released. However if it becomes necessary to submit redundant or unnecessary information for the completion of the claim forms for school, sports, or extracurricular activities; there will be an administrative fee, not to exceed $35.00, for the additional information.

Missed Appointments
We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee of $25 will apply. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees
Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to be compensated for records and our fees are

a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and or summaries. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to Apex Dental whenever applicable. I also agree, in addition to the amount owed, I am responsible for all costs of collections if such action becomes necessary.

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

CONSENT TO PROCEED

I authorize Dr. John W. Kwant, Dr. Joseph S. Maio 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 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 Doctor any prescription drugs that are currently being taken or that 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 jaw bones following oral 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 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.**

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

Doctor Signature:_____ Date:_____