JAMES D. LUND DDS

Exceptional Cosmetic and General Dentistry for the entire family.

Welcome! Thank you for choosing our dental office for your dental needs. We look forward to providing you quality care in a relaxing atmosphere!

PATIENT INFORMATION

Patient Name_____Preferred Name_____Date of Birth_____

Sex: ❒ Male ❒ Female Social Security #_____-_____-_____ (Please provide at least the last 4 digits)

Address_____ City_____ State_____ Zip_____

Phone #'s Home:_____Cell:_____Work:_____

E-mail _____

Employer_____ Occupation_____

Preferred Appointment Confirmation Method: ❒ Text ❒ E-mail ❒ Phone at this #_____

*** I authorize the use of my mobile phone number to receive scheduling and billing messages. I agree to update this office if my mobile number changes (Please initial) _____**

If patient is a minor, legal guardian?_____

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

FINANCIALLY RESPONSIBLE INFORMATION

❑ Self (if self, skip this section) ❑ Spouse ❒ Father ❒ Mother

Name_____ Date of Birth _____

Billing Address (if different from above) _____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social Security #_____-_____-_____ (Please provide at least the last 4 digits)

Employer_____ Occupation_____

E-mail address_____ D.L. No._____

EMERGENCY / ALTERNATE CONTACT INFORMATION

Name of nearest relative not living with you_____

Address_____ Home Phone_____

- I certify these answers are accurate and correct to my knowledge. Since the change of medical conditions/medications can affect dental treatment, I understand the importance of and agree to notify Dr. James D. Lund and/or any associate(s)/employee of any changes at any subsequent appointment.

Name (please print)_____ Date_____

Signature_____

Witness by Office Personnel_____

MEDICAL / DENTAL HEALTH HISTORY INFORMATION

Patient Name_____ Date_____

MEDICATIONS

Are you taking any medications? □ Yes □ No If yes, please list name of medication and reason.

_____

_____

DENTAL HISTORY

Please mark **ALL** that apply:

	Previous	Current		Previous	Current		Previous	Current
Bad breath	□	□	Grinding teeth	□	□	Periodontal treatment	□	□
Bleeding gums	□	□	Gums swollen/tender	□	□	Sensitivity to cold	□	□
Blisters on lips/mouth	□	□	Jaw pain/tiredness	□	□	Sensitivity to hot	□	□
Burning sensation on tongue	□	□	Lip/cheek biting	□	□	Sensitivity to sweets	□	□
Chew on one side of mouth	□	□	Loose teeth	□	□	Sensitivity when biting	□	□
Clicking/popping jaw	□	□	Mouth breathing	□	□	Sore/growths in mouth	□	□
Dry mouth	□	□	Orthodontic treatment	□	□	Use of tobacco/Nicotine	□	□
Fingernail biting	□	□	Pain around ear	□	□	How often do you brush_____		
						How often do you floss_____		

MEDICAL HISTORY

Please mark **ALL** that apply:

	Previous	Current		Previous	Current		Previous	Current
Aids/HIV	□	□	Epilepsy	□	□	Radiation Treatment	□	□
Anemia	□	□	Fainting or dizziness	□	□	Respiratory Disease	□	□
Arthritis, Rheumatism	□	□	Glaucoma	□	□	Rheumatic Fever	□	□
Artificial Heart Valves	□	□	Headaches	□	□	Scarlet Fever	□	□
Artificial Joints	□	□	Heart Murmur/pre-med?	□	□	Shortness of Breath	□	□
Asthma	□	□	Heart Problems/pre-med?	□	□	Sinus Trouble	□	□
Back problems	□	□	Hepatitis Type_____	□	□	Skin Rash	□	□
Bleeding, abnormal	□	□	Herpes/Cold Sores	□	□	Special Diet	□	□
Blood Disease	□	□	High Blood Pressure	□	□	Stroke	□	□
Cancer _____	□	□	Jaundice	□	□	Swollen feet/ankles	□	□
Chemical Dependency	□	□	Jaw Pain	□	□	Swollen Neck Glands	□	□
Chemotherapy	□	□	Kidney Disease	□	□	Thyroid Problems	□	□
Circulatory Problems	□	□	Liver Disease	□	□	Tonsillitis	□	□
Congenital Heart Lesions	□	□	Low Blood Pressure	□	□	Tuberculosis	□	□
Cortisone Treatments	□	□	Mitral Valve Prolapse	□	□	Tumor/growth_____	□	□
Cough, persistent or bloody	□	□	Nervous Problems	□	□	Ulcer	□	□
Diabetes_____	□	□	Pacemaker	□	□	Venereal Disease	□	□
Emphysema	□	□	Psychiatric Care	□	□	Weight Loss, unplanned	□	□

ALLERGIES

□ **Aspirin** □ **Barbiturates(sleeping pills)** □ **Codeine** □ **Latex** □ **Local Anesthetic** □ **Penicillin** □ **Sulfa** □ **Other_____** □ **None**

Reason for today's visit_____

Date of last dental visit_____ Date of last dental x-rays_____

Are you under the care of a physician? □ Yes □ No If yes, please explain: _____

Name of Physician_____ Phone Number_____

Do you require pre-medication for a medical condition? □ Yes □ No If Yes, with: _____

Have you ever taken any drugs related to fen-phen?" (Ionimin, Adipex, Fastin, Pondimin, & Redux) □ Yes □ No

Have you ever taken any bisphosphonate drugs? (Fosamax, Actonel, Boniva, or others) □ Yes □ No

Women: Taking birth control pills? □ Yes □ No Are you pregnant? □ Yes □ No If yes, due date: _____

JAMES D. LUND DDS

Financial Agreement

● Payment is due at time of service. As a condition of treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for at the time services are rendered. I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred.

● Estimated fees are extended for a period of three (3) months from the date of the patient examination.

● As a courtesy to all guests we extend the use of our outside payment service, which offers a wide variety of interest-deferred payment options as well as long-term payment plans.

● Due to the complexity of insurance contents, estimated amount(s) is/are not a guarantee of insurance, or patient payment. Insurance benefits may be subject to, but not limited to, eligibility, plan maximums and limitations, and insurance fee schedules. Any account balance over sixty (60) days will be subject to a 21% annual (1.75% monthly) service charge and late fees. I understand that it is my responsibility to provide my correct-updated insurance information and that this office will bill my insurance as a courtesy to me.

● There is a $20.00 service charge for checks that are returned unpaid.

● Patient, or financially responsible person(s), agrees to be responsible for all amounts owing. In the event any amount(s) is/are referred to a third party debt collection agency, I agree in addition to any other amount(s) allowed by law, (such as interest, late fees, reasonable attorney fees, court costs, etc.) that a collection fee of 40% of the principal amount(s) owing may also be charged to any principal balance as allowed by Utah Code Annotated, sec. 12-1-11. These terms shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

● This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial agreements or quality care, are null and void.

RESERVATION / APPOINTMENT INFORMATION

● I grant my permission to James D. Lund, DDS or his assignee to telephone me at home or at my workplace to discuss matters related to this form or concerning appointments. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

● I authorize James D. Lund, DDS, or his assignees to release financial 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.

● We make every possible effort to get each guest in to see a doctor and/or his associates/assistants/hygienists in a timely manner. To assist us in staying on schedule we appreciate respect for prompt arrival of your reservation time.

- I understand there is a $68 fee for missed or canceled appointments with less than 24-hour notice.

Thank you for reviewing this important information and respecting our business procedures. Our dental team is available Tuesday through Friday to answer any questions you may have about your account, scheduling a reservation, or just to chat. We will do everything in our power to make your visits with us exceptional!

I have thoroughly read, completely understand, and agree to cooperate with and abide by the procedures outlined above. I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

CONTINUED ON OTHER SIDE

CONSENT TO PROCEED

- I authorize James D. Lund, D.D.S. and/or such associate(s) or assistant(s), as he/she may designate, to perform necessary procedures to maintain my dental health or the dental health of any minor or other individual(s) for whom I have responsibility. These procedures include, but are not limited to, 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 effect(s), which may include but are not limited to: bruising, hematoma, cardiac stimulation, temporary or permanent numbness, and muscle soreness. I understand that on rare occasion(s) needles break and surgical retrieval may be required.
- I understand that as part of dental treatment, including preventive procedures such as hygiene cleanings and basic dentistry including restorations of all types, teeth may remain sensitive or even possibly 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 also possible for the tongue, cheek(s), or other oral tissue 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 do voluntarily assume 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(ren). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.

CONSENT FOR PHOTOGRAPHY

_____ (**Patient/Guardian Initials**) I consent to photographs, digital recordings, and/or images of me or my dependent(s) be recorded for security purposes and/or the practice's health care operations. I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recording when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified and/or my dependent(s) identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment, or health care purposes or otherwise permitted or required by law.

Notice of Privacy

Individual(s) Involved in your Care or Payment of your Care:

The dental office of James D. Lund, DDS, may disclose your health information to a spouse, family member, close personal friend, or any individual identified by you if we obtain your agreement. You have the opportunity to identify this person(s) below. We may also disclose to them if we can reasonably infer from you that you do not object to the disclosure.

The person(s) and their relationship who **MAY** receive my health information:

NAME	RELATIONSHIP	CONTACT NUMBER

- I acknowledge that I have read and received a copy of the "Office Privacy Policies and Procedures" for the dental office of James D. Lund, DDS. I acknowledge that my questions have been answered to my satisfaction. I understand that if I have questions or concerns, I may contact the HIPAA Officer: Dr. James D. Lund at (801) 254-7777.

_____ _____

Name of guest, parent/legal guardian (please print) Date

_____ _____

Signature of guest, parent/legal guardian Office Personnel Witness