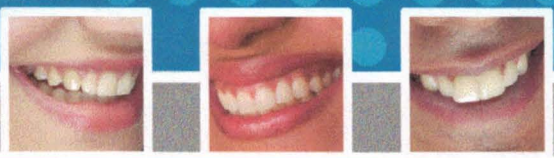
Anderson Pediatric Dental & Orthodontics, Inc.
3485 W 4800 S
Roy, UT 84067-9429

(801)774-KIDS
andersonpediatricdental@gmail.com
www.andersonpediatricdental.com



New Patient Information

Whom may we thank for referring you to our practice? (Google,Bing,DriveBy,etc..)

*

Chart #. FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: Prev. Visit: Email Address:

Phone: Home Work Ext Mobile Best time to call:

Address:

City State Zip Code

Who does the child live with?

☐ Mother ☐ Father ☐ Guardian ☐ Grandparents

List any siblings we have seen.

Is there anything that you would like to discuss with the Dentist in private, alone, or away from your child?

◯ Yes ◯ No

What is the reason for seeing the dentist today?

☐ First Visit ☐ Check-up ☐ Pain ☐ Other

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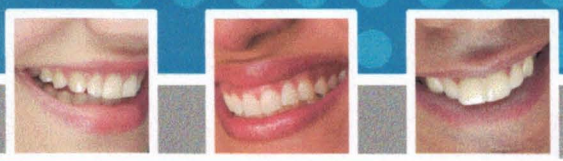

Responsible Party

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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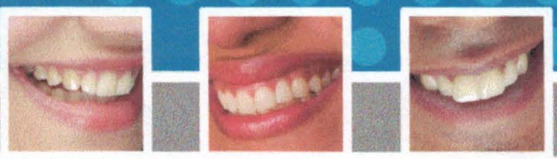

Additional Parental or Guardian Information:

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

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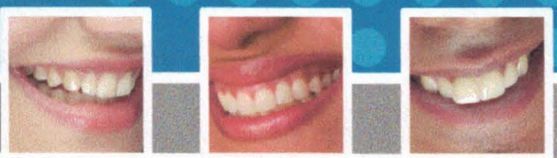

Dental Benefits Plan

Primary

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

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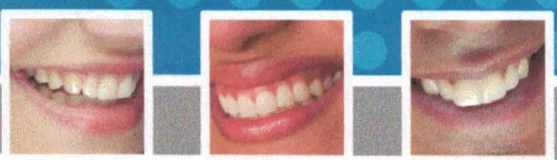

Secondary

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ (City) _____ (State) _____ (Zip Code)

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

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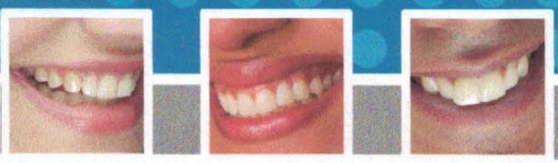

Child's Medical & Dental History

Within the past year have there been any changes in your child's general health?

◯ Yes ◯ No

What is the approximate date of your child's last medical exam?

Your child's Pediatrician, name and phone number.

Please list any medications being taken

Please indicate if your child has experienced any of the following:

☐ ADHD	☐ Allergies	☐ Anemia
☐ Antibiotic Allergy	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Augmentin	☐ Autism
☐ Blood Disease	☐ Cancer	☐ CEPHALEXIN ALLERGY
☐ CODEINE ALLERGY	☐ Diabetes	☐ Dizziness
☐ Down Syndrome	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Glaucoma	☐ Growths
☐ Hay Fever	☐ Head Injuries	☐ Hearing Impaired
☐ Heart Disease	☐ Heart Murmur	☐ Hemophilia
☐ Hepatitis	☐ High Blood Pressure	☐ HIV
☐ Jaundice	☐ Kidney Disease	☐ LATEX ALLERGY
☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders
☐ Other	☐ Pacemaker	☐ PENICILLIN ALLERGY

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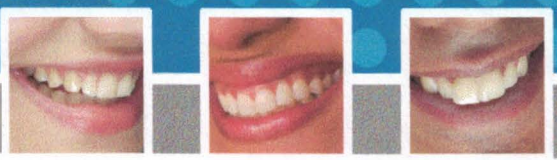

- [ ] Pregnancy
- [ ] PRE-MEDICATE
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Seizures
- [ ] Sensory Issues
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

If any of the previous questions are marked, please explain:

Has your child been to a different dental office in the last 6 months?

◯ Yes ◯ No

What was done at your child's last dental visit?

How frequently does you child brush their teeth?

- [ ] 3+ a day
- [ ] Twice a day
- [ ] Once a day
- [ ] Weekly
- [ ] Seldom
- [ ] By parent
- [ ] By child
- [ ] Both

Is your child taking a fluoride supplement?

◯ Yes ◯ No

How often does your child floss?

- [ ] Once daily
- [ ] Occasionally
- [ ] Never
- [ ] By parent
- [ ] By child

Does your child do any of the following?

- [ ] Lip sucking/biting
- [ ] Pacifier
- [ ] Nail biting
- [ ] Finger/Thumb sucking
- [ ] Nursing/Bottle
- [ ] Grinds his teeth
- [ ] Snores

- [ ] By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes in my child's health.

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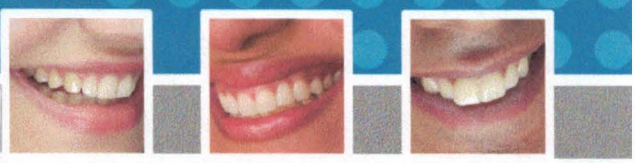

Consent for Services

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment of my insurance carrier to submit payment directly to the dentist or dental practice to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependents.

Signature: _____ Date:* _____

☐ By checking this box, I acknowledge that I have read the above conditions of treatment and payment and agree to their content. This will serve as my electronic signature.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature: _____ Date:* _____

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form. This will serve as my electronic signature.

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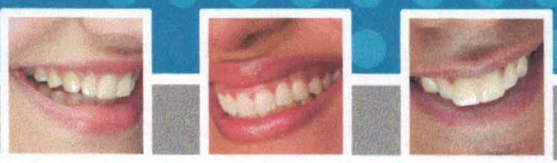

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Signature: _____ Date:* _____

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

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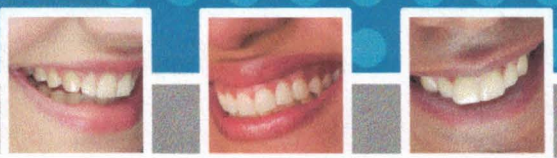

Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services 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 patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 2% per month (24% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all collection costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

Signature: _____ Date:* _____

☐ I have read the above conditions of treatment and payment and agree to their content, and this will serve as my electronic signature for the Truth-in-Lending Statement.

Relationship to Patient:

* ☐ Mother ☐ Father ☐ Guardian ☐ Other

Response Date: _____