RED HILLS
DENTAL

Dr. Matthew Bergman, DMD
162 East 300 South
St George, UT 84770

Patient

Today's Date: _____ How did you hear about us: _____

Patient Name: _____Preferred Name: _____

Address: _____ City_____ State____ Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Age: _____ SSN: _____-_____-_____ Sex: O Male O Female

Email address:_____

Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Age: _____ SSN: _____-_____-_____

O Responsible Party is also a policy holder for Patient O Secondary Insurance Holder O Primary Insurance Holder

Primary Insurance Information

Name of Insured: _____ Patient's relationship to insured: O Self O Spouse O Child O Other

Insured's Soc Sec: _____Insured's Date of Birth: _____

Employer: _____Contact: _____ Phone: _____

Insurance Company: _____ Phone Number: _____

Group #: _____ Member ID Number: _____

Secondary Insurance Information

Name of Insured: _____ Patient's relationship to insured: O Self O Spouse O Child O Other

Insured's Soc Sec: _____ Insured's Date of Birth: _____

Employer: _____ Contact: _____ Phone: _____

Insurance Company: _____ Phone Number:_____

Group #: _____ Member ID Number: _____

MEDICAL HISTORY

Patient Name: _____ Date: _____

Are you under a physician's care now? Y N
If yes, explain: _____
Have you ever been hospitalized or undergone a major operation? Y N
If yes, explain:_____ _____
Are you taking any medications, pills or drugs? Y N
If yes, explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Congenital Heart Disorder	Yes	No	High Cholesterol	Yes	No
Allergies/Sinus	Yes	No	Cortisone Medicine	Yes	No	Hives or Rash	Yes	No
Alzheimer 's disease	Yes	No	Diabetes	Yes	No	Hypoglycemia	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Irregular Heartbeat	Yes	No
Anemia	Yes	No	Epilepsy or Seizures	Yes	No	Kidney Problems	Yes	No
Angina	Yes	No	Excessive Bleeding	Yes	No	Liver Disease	Yes	No
Arthritis/Gout	Yes	No	Fainting Spells/ Dizziness	Yes	No	Lung Disease	Yes	No
Artificial Heart	Yes	No	Headaches	Yes	No	Psychiatric Care	Yes	No
Valve	Yes	No	Glaucoma	Yes	No	Radiation Treatments	Yes	No
Artificial Joint	Yes	No	Heart Attack/Failure	Yes	No	Rheumatism	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Scarlet Fever	Yes	No
Blood Disease	Yes	No	Heart Pace Maker	Yes	No	Special Needs	Yes	No
Blood Transfusion	Yes	No	Heart Trouble/ Heart Disease	Yes	No	Stomach/Intestinal	Yes	No
Breathing Problems	Yes	No	Hemophilia	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Hepatitis A	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Hepatitis B or C	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	High Blood Pressure	Yes	No	Tobacco/Marijuana	Yes	No
Chest Pains	Yes	No				Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No				Tumors or Growths	Yes	No
						Ulcers	Yes	No

Additional Comments: _____

Are you allergic to any of the following (check all that apply):

O Aspirin O Penicillin O Codeine O Acrylic O Local Anesthetic
O Metal O Latex O Sulfa O No Known Drug Allergies
O Other If yes, please explain:_____

Women: Are you

Pregnant/Trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my affirmative responsibility to inform and notify the dental office of any changes in medical status.

Signature:_____ **Date:**_____

RED HILLS
DENTAL

Consent for Treatment & Payment Agreement

I hereby authorize Dr. Matthew Bergman or designated staff to take x-rays, study models, photos, and other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize Dr. Matthew Bergman to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics and medications as necessary. I full understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf of myself or my dependents. I understand that PAYMENT IS DUE AT THE TIME OF SERVICE.

Patient Privacy Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
Obtaining payment from third party payers (e.g. my insurance company)
The day to day healthcare operations of Red Hills Dental

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you may the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations; but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent in writing at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM. I HEREBY AGREE TO ABIDE BY THE CONDITIONS OUTLINED HEREON.

Printed Name: _____

Signature: _____ Date: _____

Financial Policies & Federal Truth-In-Lending Statement

As a condition of treatment in this office, financial arrangements must be made in advance of any examination, treatment or procedure.

I understand that **PAYMENT IS DUE AT THE TIME OF SERVICE** for any and all dental services rendered.

Red Hills Dental accepts cash, checks and all major credit cards as acceptable forms of payment. For those patients needing extended-payment plans we may consider third-party financing through several outside companies. As a condition of this third-party financing, with your permission, Red Hills Dental will forward the credit application from our office. I understand that to obtain third-party financing a credit report inquiry will be required. Once third-party financing has been established, I understand that it is a contract between you and the financing company, not you and Red Hills Dental. I remain ultimately responsible to assure payment is made for all amounts due to Red Hills Dental. All account questions, payments and account servicing will be handled between you and the third party financer. In-Office Financing will ONLY be considered for well-established patients and will be determined on a case-by-case basis and is NOT a standard practice.

Although dental insurance may be applicable, I understand that all services furnished are charged directly to the responsible party listed on the New Patient Registration form and that he/she is personally responsible for payment. As a courtesy, RED HILLS DENTAL. May assist in the preparation of any and all insurance forms. Red Hills Dental does not render services on the assumption that all charges to the patient will be paid in full by an insurance company.

A service charge of $10 per month will be assessed on any unpaid balance beginning thirty (30) calendar days from initial billing. Any balance unpaid after sixty-five (65) calendar days will be assessed a 40% collection fee and the unpaid balance will be referred to an outside collection agency or attorney for collection.

Any fee estimate listed for dental care can only be extended for a period of ninety (90) days from the date the written estimate is provided by RED HILLS DENTAL

I understand that a fee of $50 will be charged if I miss or cancel an appointment without 24 hours notice. I understand that appointments requiring longer than one hour will have a $75 nonrefundable no show/cancellation fee if 48 hours notice is not given. I understand that after 3 missed/cancelled appointments I may be discharged as a patient of RED HILLS DENTAL

I understand that Red Hills Dental. Charges $25 for returned checks and personal checks will no longer be accepted as a form of payment for myself or my dependents. All future payments will require a money order, credit card or debt card.

I understand that a 20% reservation fee is required for appointments longer than 2 hours.

In consideration for the professional services rendered to the patient(s) by Red Hills Dental., I agree to pay the billed value of said services as they become due to RED HILLS DENTAL, at the time said services are rendered or within thirty (30) calendar days of billing if credit is extended. I further agree that a waiver or 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 collection be instituted to collect monies owed by me, including charges or commissions up to fifty percent (50%) that may be assessed by any collection agency or attorney retained to pursue collections.

I grant my permission to RED HILLS DENTAL and/or its agents to telephone me at home or at my workplace to discuss matters related to collections of past due accounts and/or billing. I also agree to allow messages to be left concerning appointments and/or results on my answering machine or with a family member. I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned to RED HILLS DENTAL

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM. I HEREBY AGREE TO ABIDE BY THE CONDITIONS OUTLINED HEREON.

	Relationship to patient:
Signature of patient, parent or guardian	Date: