Dr. Giaugue
FAMILY DENTISTRY

1345 E. 3900 S., Suite 210
Salt Lake City, Utah 84124
801-273-8100

PATIENT MEDICAL HISTORY

Patient's Name _____ D/O/B _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- ☐ Anemia
- ☐ Asthma
- ☐ Cold Sores or Fever Blisters
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Any Blood Disorder
- ☐ Liver Disease
- ☐ Excessive Bleeding
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ HIV Positive (AIDS)
- ☐ Nervous Disorder
- ☐ HBP
- ☐ Immune Disorder
- ☐ Pain in Jaw Joints
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Other Disease: _____

_____

Does the patient gag easily? ☐ yes ☐ no

Have tonsils and/or adenoids been removed? ☐ yes ☐ no At what age? _____

Women: Are you pregnant? ☐ yes ☐ no

Are you now or have you been under a physician's care within the past year? ☐ yes ☐ no

If yes, specify condition being treated: _____

Are medications now being taken? ☐ yes ☐ no Please list type and reason: _____

Does the patient have any allergies to: ☐ yes ☐ no

foods, medications, environmental (i.e. hay fever) _____

Do you bleed or bruise easily? ☐ yes ☐ no

Do you have or have you ever had any heart problems? ☐ yes ☐ no

Have you been told you have a heart murmur? ☐ yes ☐ no

Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? ☐ yes ☐ no

Do you have or have you ever had high blood pressure? ☐ yes ☐ no

Have you ever had any severe reaction to dental treatment or local anesthetics? ☐ yes ☐ no

Have you ever received counseling for use of alcohol and/or prescription drugs? ☐ yes ☐ no

Have you ever had bleeding or sensitive gums? ☐ yes ☐ no

Have you ever used or are you now using tobacco or alcohol? ☐ yes ☐ no

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUSEQUENT APPOINTMENT.

Signature _____ Date _____
(Patient, Legal Guardian or Authorized Agent of Patient)

OFFICE FINANCIAL POLICIES AND FEDERAL 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 our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or 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 furnished 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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 18% per month* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

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 arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable 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.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____

Signature of Patient, parent or guardian **Date**

Relationship to Patient_____

*The interest rate charged may be at the discretion of your office or accountant.

(Rev. 2/08)

OFFICE POLICY REGARDING DENTAL INSURANCE

Patients who carry dental insurance understand that all dental services furnished 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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. *However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.*

Our office will attempt to verify your insurance coverage and if possible, the amounts or percentages that your insurance company claims it will pay. This information given by your insurance company is in no way a guarantee of coverage by our office. Before giving these benefits, your insurance company gives the same disclaimer. *It is your responsibility to research your coverage policies and benefit amounts.* Our office will be happy to assist you in this process, but cannot be held liable for any estimates given.

Our office deals with over 100 different insurance companies. Each company has different underwriting policies and levels of coverage. Many will actually change the type of service performed to a cheaper alternative that they deem sufficient. Often it becomes necessary to re-bill insurance claims multiple times. *Our office is committed to making sure that you receive as much insurance money as you are due.* In the past we have billed a single claim over ten times and made phone calls by the doctor to achieve payment. Most insurance companies realize that denying a claim increases the chances they will not have to pay.

By your request, a pre-authorization can be sent to your insurance company. This usually takes about 2-8 weeks to received confirmation. This is the only way to fully guarantee coverage from an insurance company.

Our office understands that dental insurance can be a very frustrating and at times confusing thing to deal with. At your request, the doctor or his staff will provide you with either a verbal or written estimate of your co-pay amount. *Any estimates given by this office are <u>not</u> a guarantee of coverage.* We will try to make these estimates as precise as possible. It is bad business to provide you with incorrect information regarding co-pay amounts. Unfortunately, due to the third pay involvement of insurance companies, we are placed in the difficult situation of trying to anticipate how they will handle your claim. Our estimates may be completely wrong. Please remember that these estimates are provided as a courtesy and are in no way a guarantee of coverage.

The monthly billing statements that you receive have an insurance estimate included. This estimate is provided as a courtesy only. The estimate is performed by our computer software program and is only an approximation. You may pay the estimated amount or a smaller amount at that time. Once insurance has paid in full you are responsible for the entire balance. Please contact our office with any questions or to verify that the amount is correct.

Signature of Patient, Parent or Guardian	Date	Relationship to Patient

SUBMIT