Frandsen Family Dental, P.C.

3078 W. 7800 S., Ste. 7B ♦ West Jordan ♦ UT ♦ 84088

WELCOME

Today's date: _____

Thank you for entrusting your oral health care to our team of dental professionals. We are committed to serve you with the best in dental care while making your experience comfortable and relaxing. You can be assured of a thorough diagnosis and complete plan for your treatment.

Please provide the following information:

PATIENT INFORMATION

Full Name _____ **Married Single / Male Female**
Last, First & Initial

Name Patient Prefers to be called _____ Email Address _____

Home Address_____ City_____ State_____ Zip Code_____ How Long_____

Phone # _____/_____/_____
Home Work Cell

SS# _____ Birth Date _____/_____/_____
Month Day Year

PRIMARY INSURED OR RESPONSIBLE PARTY INFORMATION

Full Name _____ Email Address _____
Last, First & Initial

Home Address_____ City_____ State_____ Zip Code_____ How Long_____

Phone # _____/_____/_____
Home Work Cell

SS# _____ Birth Date _____/_____/_____
Month Day Year

Employer_____ /_____
Phone number

DENTAL INSURANCE COMPANY INFORMATION

Name Primary Insurer _____ Group # / ID# _____

Address _____
Street, City, State, Zip Code

*If you have **DUAL** dental coverage:*

Name Secondary Insurer _____ Group # / ID# _____

Frandsen Family Dental, P.C.

165 South Orem Boulevard □ Orem □ UT □ 84058

Address _____
Street, City, State, Zip Code

EMERGENCY AND OTHER INFORMATION

In case of emergency whom do we contact _____ Phone # _____

Relative's Name _____ Phone # _____
(Not living with you)

Thank you *for furnishing this important information.*

DENTAL INFORMATION

What is the ***MAIN*** reason you initiated this dental visit?

_____

Do you have any other dental needs or concerns of which you are aware?

_____

CHECK any dental topic(s) you would like to discuss with the Doctor or Staff:

- □ Periodontal (gum) Disease
  - o Heart Disease o Diabetes o Pregnancy
- □ Teeth Whitening
- □ White Fillings
- □ Cosmetic Dentistry
- □ Nitrous (relaxing) Gas
- □ Hygiene Techniques
- □ Replace Missing Teeth
  - o Bridges o Implants
- □ Radiation Exposure
- □ Other _____
- □ Local Anesthetic
- □ Night Grinding/Guard
- □ Clenching Teeth
- □ Implants
- □ Bleeding Gums
- □ Smile Improvement
- □ Amalgam Removal
- □ Root Canals (Endodontist)
- □ Veneers/Bonding
- □ Dental Phobia
- □ Sedation (twilight sleep) o Children o Adults
- □ Crown
- □ Bridges
- □ Sealants (groove coating)
- □ Bad Breath
- □ Sterilization in this office
- □ Braces (Orthodontist)
- □ Fractured/Chipped Teeth
- □ Pregnancy Precautions
- □ Wisdom Teeth Removal
- □ TJM Popping/Discomfort
- □ Fluoride Treatments
- □ BC Pills with Antibiotics
- □ Antibiotic Premedication

REFERRAL INFORMATION

CHECK ALL THAT APPLY AND ***CIRCLE*** the item most significant in your decision to seek care with us.

□ Frandsen Family Dental website

Thank you *for furnishing this important information.*

☐ I was referred by: _____ (please print complete name)

☐ I know this referring individual as a _____ (work, colleague, neighbor, family, friend, etc)

☐ The dental office is convenient because it is close to my home

☐ I found your name listed in my employer or insurance company list of participating dentists ☐ Telephone Book

☐ Val Pak Mailer

Other: _____

ACKNOWLEDGEMENT OF RECEIP OF NOTICE OF PRIVACY PRACTICES

I, _____have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

Frandsen Dental

165 South Orem Blvd., Orem UT 84058

DENTAL INFORMATION

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- o Heart Disease o Diabetes o Pregnancy

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☐ White Fillings

☐ Cosmetic Dentistry

☐ Nitrous (relaxing) Gas

☐ Hygiene Techniques

☐ Replace Missing Teeth
- o Bridges o Implants o Dentures/ Partials

☐ Radiation Exposure

☐ Local Anesthetic

☐ Night Grinding/Guard

☐ Clenching Teeth

☐ Radiation Exposure

☐ Bleeding Gums

☐ Smile Improvement

☐ Amalgam Removal

☐ Root Canals (Endodontist)

☐ Veneers/Bonding

☐ Dental Phobia

☐ Sedation (twilight sleep) o Children
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☐ Crowns

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☐ Antibiotic Premedication

□ Other _____

REFERRAL INFORMATION

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Telephone Book

□ Audio Information

□ Post Card Mailing

Other: _____

PLEASE LEAVE REST BLANK FOR OFFICE PERSONELL

NPGB_____ NPTR_____ PANO_____

COMMENTS:

FINANCIAL AND INSURANCE ARRANGEMENTS

As condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the cost 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 at the time services are rendered.

Thank you *for furnishing this important information.*

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. We will credit any such collections received to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by an insurance company. Benefit explanations that accompany insurance payments (EOB) are to be retained by you. They are important in resolving your benefit payment questions with your insurance carrier. If a copy is required it can be obtained from your carrier.

We will estimate the portion of the total fee that your insurance company may cover. This is not a guarantee of payment. Please pay your estimate co-payment and deductibles (not covered amount) at each time of service. We allow an interest-free 60-day grace period for your insurance payment. If your insurance company does not pay within 60 days from treatment, we expect you to pay the balance and obtain reimbursement from your insurance company. We do not carry balances or allow monthly payments without prior credit approval and financing agreements.

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. A late fee of $10 will be charged on the last day of the month if no payment. 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 me, or at my request for my minor child or ward by dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within five (5) days of billing if a remaining balance after insurance payment. I further agree that the reasonable value of said services shall be as billed unless objected to by me in writing, within the time for the payment thereof. 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. Should collection become necessary the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs. I authorize the release of financial information concerning my account, including attorney charges billed, payments made, etc. to the dentist's collection attorney should collection procedures as described become necessary.

I grant my permission to the dental office to telephone me at home or at my workplace to discuss dental related matters.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and any information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I authorize my insurance company to make payment directly to the dental office for services rendered and agree to pay any remaining unpaid claim within 60 days from the date of the service. I understand that I will not be assessed finance charges during this 60 day grace period for receiving my insurance payment.

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

I hereby agree to abide by the conditions outlined herein.

SIGNATURE (18 years or older) **DATE**

Frandsen Family Dental, P.C.
165 South Orem Boulevard Orem UT 84058

MISSED APPOINMENT POLICY AND AGREEMENT

It is our intent at **Frandsen Family Dental, P.C**., to provide the best oral health care value in the area. We strive to both provide the highest quality of care while keeping the cost of dental care down. To do this, we are continually looking for ways to be more efficient while simultaneously improving the services we render to our patients. We understand that our patients require unsurpassed care that is delivered in a timely fashion.

A significant area of lost efficiency (and therefore increased costs) is when a patient has a reserved appointment time and fails to keep it. Many other practices solve this dilemma by "double booking" their patients, so that if one fails they have another patient waiting for care. But at **Frandsen Family Dental**, we have left that our patient's time is valuable too and have not wanted to resort to double booking, as it often leaves patients lingering in the reception room for longer periods of time.

Therefore, when an appointment is made here, it is reserved solely for the schedule patient. (Patients in pain are seen in a priority manner and without reserved times. These emergencies occasionally result in appointments being delayed for short period). When reserved appointments are missed without several business days of advance notice, the time is often wasted without productive care being delivered. Thus raising oral health costs for everyone.

Please be informed, that to help our practice stay as efficient as possible, we require a minimum of two business days of advance notice to change the status of an appointment. Also, leaving a message on the phone can be misunderstood or delay notification of schedule changes, so please always speak directly to a business office person when needing to alter a reserved appointment. Appointments that are changed or missed without two business days of advance notice will result in the assessment of any associated missed appointment fee. (The amount is often determined by the patient's own insurance carrier and usually ranges between $25 and $45 per appointment missed).

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_____ _____

SIGNATURE (18 years or older) **DATE**

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CONSENT TO PROCEED

I authorize **Dr. Brian Frandsen** and/or such associates or assistants as he/they 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 brushing, hematoma, cardiac stimulation, muscle soreness and temporary or rarely, permanent numbness. I do voluntarily assume any possible risk , 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 benefic of my minor child or ward. I acknowledge that the nature and the purpose of the foregoing procedures have been explained to me (if necessary or requested) and I have been given the opportunity to ask question.

_____ _____

SIGNATURE (18 years or older) **DATE**

Thank you *for furnishing this important information.*