Welcome To

DAVID R BLACKHURST DDS
FAMILY AND COSMETIC DENTISTRY

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Patient #_____
SS # _____
Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's or Parent's Employers _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

DAVID R BLACKHURST DDS
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FINANCIAL POLICIES

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.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. Unless you and this Dental office have entered into a separate written and signed agreement stating otherwise, payment in full is due at the time of service. If payment in full is not made, in addition to all other amounts that may be due I agree to pay a collection fee of up to 40% of the principal amount as provided by Utah law. and further agree to pay all other costs of collection (incurred by Blackhurst Dental or its assigns) including but not limited to court costs, reasonable attorney fees, and interest (both pre- and post-judgment) at the rate of 1.5% per month (18% per annum).

Missed Appointments: Please notify us ONE DAY prior to you APPT. We schedule your appointment for you specifically, SO FAILURE TO GIVE US TIME TO RESCHEDULE ANOTHER PATIENT WILL RESULT IN A $60.00 MISSED APPOINTMENT CHARGE. Please help us serve you better by keeping scheduled appointments. We would be happy to work with you to plan the most appropriate arrangements for your budget.

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 hereby agree to abide by the conditions outlined herein.

_____ _____

Signature of Patient, Parent or Guardian Date

_____

Relationship to Patient

DAVID R BLACKHURST DDS
FAMILY AND COSMETIC DENTISTRY

Patient Name:_____

MEDICAL HISTORY

Physician's Name _____

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, describe _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates_____

Have you ever taken Redux or Fen-Phen? ❑ Yes ❑ No

Are you or have you ever taken Fosamax, Actonel, Boniva, Zometa or Aredia? ❑ Yes ❑ No

Have you ever been treated for osteoporosis? ❑ Yes ❑ No

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems, *Describe:* _____
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus Infection
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Vitamin B12 Deficiency

MEDICATION	ALLERGIES
List medications you are currently taking:	

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Address _____

Date of last dental visit _____ Date of last dental X-rays _____

DAVID R. BLACKHURST DDS

CONSENT TO PROCEED

I authorized Dr. David R Blackhurst and/or such associates or assistants as he 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 anesthetics may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings 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 or other oral tissues 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 understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complications of non-healing of the jawbones following oral surgery.

I do voluntarily assume any and 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 or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature:_____Date:_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ Date:_____