WASATCH PERIODONTICS
AND IMPLANT DENTISTRY

DANIEL H. THUNELL, D.M.D.

WELCOME TO OUR OFFICE

Full Name: Mr. Mrs. Ms. Miss Dr.		Preferred Name:	
Residence Address:	City:	State:	Zip:
Date of Birth:	Social Security #:	Residence/Cell Phone:	Business Phone:
Employed By:		Occupation:	
Name of Spouse/Parent (if a minor):		E-mail Address:	
Nearest Relative not living with you (name, address, phone):			

Payment for today's visit and future visits is due at time of service. We may accept assignment of benefits and will submit your claims as a courtesy to you. **If you have insurance, the amount quoted prior to treatment is our best estimate based on what your insurance provider tells us.** The balance is your responsibility regardless of your insurance benefit. Your insurance policy is a contract between you and your insurance company. We will do our best to make the most of your insurance benefit. Thank you for understanding our Financial Policy.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I also understand that I am responsible for any interest (1.5% per month), collection fees (an additional 40% added to balance), reasonable attorney fees and court costs that may occur due to non-compliance of these terms.

Signature Date:

ADDITIONAL INFORMATION

General Dentist:	Phone (if known):
Whom may we thank for referring you?	

DENTAL INSURANCE INFORMATION

Employee's Name:	Relationship to Patient:
Insured's Employer:	Date of Birth:
Insurance Company:	ID Number:
Insurance Company Address:	Phone #:
Are you covered by a secondary insurance company? Yes No	
If yes, Secondary Insurance Company:	ID Number:
Insurance Company Address:	Phone #:
Employee's Name:	Relationship to Patient:
Insured's Employer:	Date of Birth:

IF UNDER 18 OR FULL TIME STUDENT (Responsible Party Information)

Name:		
Address:		
Telephone (Home):	Telephone (Work):	Social Security #:

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DANIEL H. THUNELL, D.M.D.

MEDICAL HISTORY

		YES	NO
1.	Are you in good health? If not, explain:		
2.	Has there been any change in your general health within the past year? Please specify:		
3.	Are you taking any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking?		

4.		YES	NO
a.	High blood pressure		
b.	Heart murmur or prolapsed valve		
c.	Rheumatic fever or rheumatic heart disease		
d.	Congenital heart disease		
e.	Sinus trouble		
f.	Asthma or hay fever		
g.	Fainting spells or seizures		
h.	Diabetes		
i.	Hepatitis, jaundice or liver disease		
j.	Arthritis		
k.	Artificial joints		
l.	Cosmetic Surgery		

		YES	NO
m.	Cardiovascular disease: heart attack, stroke		
n.	Prosthetic heart valve		
o.	Blood disorder (i.e. Anemia)		
p.	Temporomandibular joint problems (TMJ)		
q.	Kidney trouble		
r.	Thyroid		
s.	Tuberculosis		
t.	Do you have a persistent cough		
u.	Stomach ulcers		
v.	Cancer		
w.	AIDS or immunosuppressive disorder		

		YES	NO
5.	Are you allergic or have you had a reaction to any drug or medicine? If so, what?		
6.	Do you have any disease, condition, or problem not listed above that you think I should be aware of? If so, explain		
7.	Do you smoke? If so, how much and for how long?		
8.	Do you take any medication for osteoporosis or osteopenia?		
WOMEN			
9.	Are you pregnant/nursing?		
10.	Are you taking birth control pills or hormones?		

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. If necessary, this office may share medical/dental information with your dentist or other specialists to help consult with what treatment may be best for you.

Signature Date:

MEDICAL HISTORY UPDATE

DATE	CHANGES	PATIENT'S INITIALS