Dustin J. Farris D.M.D
370 E. South Temple, Suite 220
Salt Lake City, UT 84111
(801)355-8287

Date_____ SS#_____

Patient Name_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Birth date_____ M/F_____ Marital Status_____

Patient's or Parent's (if patient is a minor) Employer_____

Work Phone_____ Occupation_____

Spouse's Name_____ Employer_____

Work Phone _____ Occupation_____

Billing Name/Address_____

Person to Contact in Case of Emergency_____ Phone_____

Whom May We Thank for Referring You?_____

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PRIMARY INSURANCE

Name of Person Who Carries Primary Dental Insurance_____

Carrier's Birth date_____ Carrier's Employer_____

Insurance Company_____ Phone_____

Dental Claims Mailing Address_____

Group #_____ Subscriber ID# or SS#_____

SECONDARY INSURANCE

Name of Person Who Carries Secondary Dental Insurance_____

Carrier's Birth date_____ Carrier's Employer_____

Insurance Company_____ Phone_____

Dental Claims Mailing Address_____

Group #_____ Subscriber ID# or SS#_____

OVER PLEASE

Dental History

Reason for Today's Visit_____
Former Dentist_____ Location_____
Date of Last Dental Visit_____ Date of Last Dental X-rays_____

Check all that apply:

_____ Bad breath	_____Grinding teeth	_____Sensitivity to heat
_____Bleeding gums	_____Loose teeth	_____Broken teeth
_____Clicking/popping jaw	_____Throbbing in teeth	_____Sensitivity to sweets
_____Sensitivity to cold	_____Sensitivity when biting	_____Food Collection between teeth
_____Broken fillings	_____Sores or growths in mouth	_____Prior periodontal treatment

How often do you brush?_____ How often do you floss?_____

Medical History

Physician's Name_____ Date of Last Visit_____
Have you had any serious illnesses or operations? Y/N_____ If yes, describe_____
_____
Have you ever had a blood transfusion? Y?N_____ If yes, give approximate date_____
(Women) Are you pregnant?_____ Nursing?_____ Taking birth control pills?_____

Circle all that apply (Current or Past):

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

List Medications you are Currently Taking_____
_____
Are you taking any medication for osteoporosis?_____
Allergies_____

AUTHORIZATION AND RELEASE
I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to Dustin Farris, D.M.D. otherwise payable to me. I authorize Dr Farris to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. If, in the event of default in payment, it becomes necessary to collect by suit or otherwise, patient agrees to pay all collection costs incurred by the dentist including 40% collection fee and reasonable attorney's fees. I authorize the use of this signature on all insurance submissions. I understand that an interest rate of 1.5% APR will be included on any outstanding balance over 90 days.

Signature_____
Date_____
Signature of patient or parent if minor Date

Consent to proceed

I authorize Dr. Farris and/or such associates or assistants as s/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 anesthetic may cause an untoward reaction or side effects, which may include, but 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 instrument, 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 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 foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____
(please print)

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

Witness:_____ Date:_____