NEIL J. DANSIE D.D.S.
FAMILY DENTISTRY

(PLEASE PRINT)

Patient Name_____ Nickname _____Date _____

Home Phone:( )_____ Birthdate: _____ Age: _____ Sex: ( ) Male ( ) Female

Address: _____ City:_____ St._____ Zip _____

Patient's Guardian_____ Relationship _____

Whom may we thank for referring you to us or how did you discover our office? _____

In Case of Emergency Call:_____

Address:_____ Phone:_____

Nearest Adult relative not living with you:

Name _____Relationship _____Phone _____

Address_____City _____St._____Zip_____

PERSON RESPONSIBLE FOR PAYMENT: _____ S.S.# _____

Address: _____ City: _____ St. _____ Phone _____

Employer: _____ Address: _____ Phone _____

Spouse's Name_____ Address:_____

S.S.# _____ Employer_____ Work Phone_____

INSURANCE INFORMATION:

Insurance Name of Carrier _____ Group # _____

Address: _____ Phone # _____

_____ SS # _____

Name of Employee: _____ Birth Date _____

Employer: _____

Name of 2nd Carrier_____ Group # _____

Address: _____ Phone # _____

_____ SS # _____

Name of Employee: _____ Birth Date _____

Employer: _____

In accordance with the Federal Truth-In-Lending Act, please be advised of the following policies in connection with the extension of credit. By signing this agreement, the responsible party agrees to;

1. **PAY** in full each time services are rendered. We accept cash, check, or major credit cards.
2. **PAY** 1.75% per month (21% APR) on any unpaid balance that extends over 30 days, with a minimum of $2.00. Financial arrangements must be made prior to first appointment.
3. Authorize a credit report to be obtained if deemed necessary.
4. In the event that full payment for charges incurred in my dental care is not made, I agree to pay all costs of collections, including a 45% Collection Agency Commission, plus all collection/court costs, reasonable attorneys' fees if delinquent balance is placed with a collection agency or attorney. I also agree to submit myself to the jurisdiction of the courts of Utah County, Utah.

Signature_____ Date _____

READ AND SIGN BACK OF THIS FORM.

PERSONAL REFERENCE

PATIENT'S NAME_____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment. I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Neil J. Dansie, D.D.S. 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 are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks, including 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.

MEDIATION AGREEMENT: Should any claim or controversy arise between the patient and/or a legally authorized representative of the patient and dentist concerning the care and treatment rendered by the dentist to the patient, an effort shall be made by the parties involved to resolve the dispute through mediation according to the rules of WESTERN MEDIATION, should the dispute pertain to the quality of the dental services rendered. Thus, a claim or controversy shall first be submitted to non-binding mediation. Costs for the mediation services shall be shared equally by the parties involved. The foregoing mediation agreement does not pertain to actions taken for the collection of debts owed as a result of dental services rendered.

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

Witness _____ Date _____