Bradley S. Rigby, D.M.D., P.C.
Daniel M. Cohen, D.M.D.
1561 West 7000 South Suite #101
West Jordan, Utah 84084
Phone: (801) 255-7600 Fax: (801) 676-0082

R I G B Y D E N T A L

Welcome

It is a pleasure to serve you! Please fill out the front and back completely. The better we communicate, the better we can help you. If you have any questions, please ask.

PATIENT INFORMATION

NAME ____________________
PREFERRED NAME ____________ ☐ MALE ☐ FEMALE
HOME # ____________ MOBILE # ____________
WORK # ____________ EXT ____________
BIRTHDATE ____/____/____ AGE ____________
SS# ______-_____-______
ADDRESS ____________________
____
CITY ____________ STATE ______ ZIP ______
EMAIL ADDRESS ____________________
☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
EMPLOYER ____________________
HOW LONG THERE? ________ OCCUPATION ____________
FAMILY MEMBERS SEEN BY US ____________________

RESPONSIBLE PARTY INFORMATION

☐ Same as patient

NAME ____________________
PREFERRED NAME ____________ ☐ MALE ☐ FEMALE
HOME # ____________ MOBILE # ____________
WORK # ____________ EXT ____________
BIRTHDATE ____/____/____ AGE ____________
SS# ______-_____-______
ADDRESS ____________________
____
CITY ____________ STATE ______ ZIP ______
EMAIL ADDRESS ____________________
☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
EMPLOYER ____________________
HOW LONG THERE? ________ OCCUPATION ____________
FAMILY MEMBERS SEEN BY US ____________________

IN THE EVENT OF EMERGENCY, IS THERE SOMEONE NOT LIVING WITH YOU THAT WE COULD CONTACT?

____
NAME RELATIONSHIP WORK # HOME #

REFERRAL SOURCE: ☐ FRIEND/FAMILY ____________ ☐ INSURANCE ☐ MAILER/AD ☐ WALK IN
☐ GOOGLE ☐ INTERNET ☐ FACEBOOK ☐ OTHER ____________

PRIMARY DENTAL INSURANCE INFORMATION

INSURANCE NAME ____________ POLICY HOLDER ID # ____________
POLICY HOLDER NAME ____________ BIRTHDATE ____/____/____ SS# _____-_____-_____
EMPLOYER ____________ RELATIONSHIP TO PATIENT ____________

SECONDARY DENTAL INSURANCE INFORMATION

INSURANCE NAME ____________ POLICY HOLDER ID # ____________
POLICY HOLDER NAME ____________ BIRTHDATE ____/____/____ SS# _____-_____-_____
EMPLOYER ____________ RELATIONSHIP TO PATIENT ____________

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

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. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered. 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 for our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. A monthly service charge at a fixed rate of 1.5%per month/18%per annum of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding ninety (90) days from the date of service unless previously written financial arrangements are made. 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 be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary. I grant my permission to you or your assignee to telephone me at home, including calls or texts to mobile, cellular, or similar devices for any lawful purpose. I agree to pay any fee(s) or charge(s) that I may incur for incoming calls or outgoing calls, without reimbursement. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void. 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 certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein. I agree to pay the remaining balance plus all collection/court costs and fees (33% of the balance) if a delinquent balance is placed with a collection agency or attorney.

There is a $25.00 per hour charge for appointments missed without 24 hour notice.

____
Signature of Patient or Guardian Relationship to Patient Date

Continue on back →

DENTAL HEALTH

HAVE YOU COME TO THE OFFICE FOR PAIN RELIEF? ☐ YES ☐ NO IF YES, HOW LONG HAS IT HURT? ____________

DOES IT HURT WITH? ☐ HOT ☐ COLD ☐ SWEETS ☐ CONSTANTLY

HOW LONG SINCE YOU'VE BEEN TO A DENTIST?__________YEARS __________MONTHS

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? ☐ YES ☐ NO IF NOT, WHY? ____________

HAVE YOU EVER HAD ANY INJURY TO YOUR FACE OR JAW? ☐ YES ☐ NO IF YES, EXPLAIN? ____________

HAVE YOU EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK? ____________

CHECK IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING

- ☐ BAD BREATH
- ☐ BLEEDING GUMS
- ☐ CLICKING OR POPPING JAW
- ☐ FOOD CAUGHT BEWTEEN TEETH
- ☐ BROKEN FILLINGS
- ☐ CLENCH/GRINDING TEETH
- ☐ LOOSE TEETH
- ☐ PERIODONTAL TREATMENT
- ☐ SENSITIVITY TO COLD
- ☐ SENSITIVITY TO HOT
- ☐ SENSITIVITY TO SWEETS
- ☐ SENSITIVITY WHEN BITING
- ☐ SORES OR GROWTH IN MOUTH
- ☐ OTHER ____________

MEDICAL HISTORY

ARE YOU NOW BEING TREATED OR HAVE YOU BEEN TREATED IN THE LAST YEAR BY A PHYSICIAN? ☐ YES ☐ NO EXPLAIN ____________

NAME OF PHYSICIAN ____________ PHONE # ____________

NAME OF PREVIOUS DENTIST ____________

ARE YOU TAKING ANY PRESCRIPTIONS, DIET, OR OVER THE COUNTER MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY NAME AND PURPOSE OF EACH MEDICATION ____________

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ☐ ARTHRITIS, RHEUMATISM
- ☐ ASTHMA
- ☐ CHEMOTHERAPY
- ☐ HEART MURMUR
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ PACEMAKER
- ☐ TOBACCO HABIT
- ☐ SMOKE ☐ CHEW ☐ VAPE: FREQUENCY ____________
- ☐ ARTIFICIAL HEART VALVES
- ☐ BLOOD DISEASE
- ☐ DIABETES
- ☐ HEART PROBLEMS
- ☐ HIV/AIDS
- ☐ LIVER DISEASE
- ☐ RHEUMATIC FEVER
- ☐ TUBERCULOSIS
- ☐ ARTIFICIAL JOINTS (HIP OR KNEE)
- ☐ CANCER
- ☐ EPILEPSY/FAINTING
- ☐ HEPATITIS
- ☐ JAW PAIN
- ☐ MITRAL VALVE PROLAPSE
- ☐ THYROID PROBLEMS
- ☐ (WOMEN) ARE YOU PREGNANT? ☐ YES ☐ NO DUE DATE ____________ NURSING? ☐ YES ☐ NO TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO
- ☐ OTHER ____________

ALLERGIES

CHECK IF YOU HAD ANY UNUSUAL OR ALLERGIC REACTIONS TO ANY OF THE FOLLOWING:

- ☐ NO ALLERGIES KNOWN
- ☐ PENICILLIN/AMOXICILLIN
- ☐ CEPHALEXIN
- ☐ CODEINE, HYDROCODONE
- ☐ OTHER NARCOTIC ____________
- ☐ LATEX
- ☐ EPINEPHRINE, LOCAL ANESTHETIC
- ☐ ERYTHROMYCIN
- ☐ TETRACYCLINE
- ☐ METALS(NICKEL OR GOLD)
- ☐ NSAID-MOTRIN
- ☐ ASPIRIN
- ☐ ACRYLIC
- ☐ OTHER ____________

CONSENT TO PROCEED

I authorize Dr. Bradley S. Rigby 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, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation. 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. Dental materials and medications may trigger allergic or sensitivity reactions. I am aware Rigby Dental does not use amalgam(mercury) fillings to restore teeth. I understand if my insurance does not cover composite fillings, I am responsible to pay the difference. After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. 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, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions. 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.

____________ Date

____________ Name of Patient(Please Print)

____________ Responsible Party Signature

MEDICAL UPDATES

DATE	EXCEPTIONS	RESPONSIBLE PARTY SIGNATURE	REVIEWED BY
		None	Dr.
		None	Dr.
		None	Dr.
		None	Dr.