Mountain Dentistry
2053 Sidewinder Dr.
Park City, Utah 84060

(435) 645-8500

S. Scott Kimche DDS
Welcome to Our Office!

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

PATIENT INFORMATION

First Name & Last Name _____

Mailing Address _____ City _____

State _____ Zip _____ Email Address _____

Telephone (H) _____ Telephone (W) _____Telephone (C)_____

SSN _____ Date of Birth _____

Employer _____ City/State _____

Marital Status: Single _____ Married _____ Divorced _____ Widow _____ Spouse _____

Sex: Male / Female

Who May We Thank For Referring You to Our Office? _____

Contact In Case of Emergency _____ Telephone _____

DENTAL HISTORY

Reason for today's visit_____

Have you ever had trouble with a previous dental treatment? If so, please describe: _____

Date of last regular dental check up_____

Do you require antibiotics before dental treatment? YES ___ NO ___

Do your gums ever bleed? YES___ NO ___

Have you noticed any mouth odors or bad tastes? YES ___ NO ___

Are your teeth sensitive to heat/cold? YES ___ NO ___

Do you still have your wisdom teeth? YES ___ NO ___

MEDICAL HISTORY

Primary Care Physician _____ Phone _____

Have you been under a physician's care in the last 2 years? YES NO

If yes, describe briefly _____

Have you ever been hospitalized or had a major operation/illness? YES NO

If yes, describe briefly _____

Are you currently taking any prescription medications, pills, or drugs? YES NO

If yes, please list _____

Are you allergic to any of the following medications/materials?

Aspirin _____ Penicillin _____ Codeine _____ Latex Rubber _____ Acrylic _____ Other _____

If "Other", please list _____

Women only: Pregnant/Trying to get pregnant _____ How many Wks._____ Nursing _____ Taking oral contraceptives _____

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	___	___	**Bruise Easily**	___	___	**Drug Abuse**	___	___
Heart Murmur	___	___	**Anemia**	___	___	**Alzheimer's disease**	___	___
Irregular Heart Beat	___	___	**Excess Bleeding**	___	___	**Epilepsy/Seizures**	___	___
Angina/Chest Pain	___	___	**Hemophilia**	___	___	**Cancer/X-ray Treatment**	___	___
Heart Attack/Stroke	___	___	**Swelling of Limbs**	___	___	**Stomach/Intestinal Disease**	___	___
Congenital Heart Problem	___	___	**Lung Disease**	___	___	**Ulcers**	___	___
Valve Prolapse	___	___	**Difficulty Breathing**	___	___	**Recent Weight Loss**	___	___
Rheumatic Fever	___	___	**Sinus Trouble**	___	___	**Diabetes**	___	___
Artificial Heart Valve	___	___	**Asthma**	___	___	**Hypo/Hyperglycemia**	___	___
Pace Maker	___	___	**Emphysema**	___	___	**Liver Disease/Hepatitis**	___	___
Heart Surgery	___	___	**Tuberculosis**	___	___	**Kidney Problems**	___	___
Artificial Joints	___	___	**Thyroid Disease**	___	___	**Venereal Disease**	___	___
High Blood Pressure	___	___	**Glaucoma**	___	___	**AIDS**	___	___
Blood Disease	___	___	**Convulsions**	___	___	**HIV Positive**	___	___

Do you wish to review any condition privately with Dr. Kimche? Yes/No

DENTAL INSURANCE INFORMATION

Insurance Company _____

Address _____

City _____State_____ Zip _____

Phone _____Group # _____

Employer _____

Employee Name _____

SSN _____ID#_____ DOB _____

*****IF UNDER 18 PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT*****

Name_____Relationship to patient_____

Social security no._____Phone_____

Drivers license no._____Date of birth_____

Address (Street, City, State, ZIP) _____

Employer_____Work phone_____

Preferred payment method: Cash___ Credit Card___

Visa/MC/AMEX no._____ Exp. Date_____

If patient is a minor, name of parent or legal guardian and relationship_____

Is this parent or legal guardian currently a patient in our office? YES ___ NO ___

PATIENT SIGNATURE (parent/guardian)_____DATE_____

Office Financial Policies and Federal Truth-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charge directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurances companies and will credit any such collection received to patents account. However, this dental office cannot render services on the assumption that our charges will be paid in full by and insurance company.

A service charge of 1 1/2 % per month (18% per annual) on the unpaid balance will be assessed on all accounts exceeding sixty (60) 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 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 to the dentist or his/her assignee at the time the services are rendered or within five (5) days of billing if credit shall be extended. I agree to pay the remaining balance plus attorneys fees. Court costs and collections agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or a attorney, 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 collections attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my work place to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement s supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that my 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 description 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 individual with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, Parent or Guardian Relationship to Patient Date

SMILE ANALYSIS

Do you love the way your smile looks? YES___ NO___

Do you feel comfortable showing your teeth when you laugh or smile? YES___ NO ___

If you could change anything about your smile, it would be (check all that applies):

__Color of your teeth ___Too much or too little of teeth show when you smile ___Gaps between your teeth

__Size/Shape of your teeth ___ Too much or too little of gum shows when you smile ___Alignment of your teeth

__Other:_____

Do you have(Check all that apply)

___Sensitive or receding gums ___Worn/broken/chipped teeth ___Old discolored fillings __Missing teeth

___ Old crowns that have dark edges at the top ___Other:_____

In your line of work or lifestyle, do you (check all that apply):

___ Visit businesses or clients ___Travel ___Speak publicly ___Other:_____

If you had a smile makeover do you think you'd feel (check all that apply)

___More confident ___More optimistic ___Healthier

___Just OK ___No different ___Other:_____

Do you or someone in your family have issues with any of the following (check all that apply):

___Chronic bad breath ___Grinding teeth ___Snoring

___Other:_____

We'd like to know more about you so we can better serve you!

Do you prefer appointments in the (check all that apply):

__Early morning __Early afternoon __No preference

__Late morning __Late afternoon __Other:_____

What type(s)of music do you enjoy?

__Easy Listening __Classical __Rock __Hip-Hop/Rap

__Jazz __Country __R&B __Other:_____

What are your favorite hobbies or activities?

_____

_____

Is there anything else that you want our office to know about you that will help us serve you better?

_____