Stephen J. Davis, D.D.S.

3950 S. 700 East, Suite 206
Salt Lake City, UT 84107-2114
801.263.2236

Section I: Patient Information Today's Date_____

Name:_____ I Prefer to be called: _____
Date of Birth:_____/_____/_____ Social Security Number:_____-_____-_____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
Email Address_____ Would you like to receive our email? ☐ Yes ☐ No
The best time to contact me is:_____ ☐ A.M. ☐ P.M. ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse or Parent's Name:_____ Employer_____
Whom may we thank for referring you to our office? _____
In case of an emergency please contact_____ Phone(_____)_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____
Have you ever taken out bankruptcy or defaulted on any credit obligation?_____ If yes, explain:_____
I agree that a reasonable charge may be assessed for any appointments which are broken or canceled within 24 hours notice. I understand that I am financially responsible for all charges regardless of insurance coverage. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine. **Payments are due at the time of service.** I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I promise to pay legal interest on the indebtedness, together with a 33-50% collection fee, collection costs, and attorneys fees as may be required to effect collection of this note.
Signed_____Date_____

Section III Insurance Information

Name of Insured_____DOB_____/_____/_____Relationship to Patient _____
Insurance Company_____
Ins Co Address:_____ Ins Co. Phone:_____
Grp #_____ ID#_____ SSN#_____-_____-_____
Name of Employer_____ Work Phone: (_____)_____-_____
Address of Employer:_____City_____State_____ Zip_____
DO YOU HAVE ADDITIONAL INSURANCE? _____ IF SO PLEASE FILL OUT INFORMATION BELOW----------
Name of Insured_____DOB_____/_____/_____Relationship to Patient _____
Insurance Company_____
Ins Co Address:_____ Ins Co. Phone:_____
Grp #_____ ID#_____ SSN#_____-_____-_____
Name of Employer_____ Work Phone: (_____)_____-_____
Address of Employer:_____City_____State_____ Zip_____
I authorize release of any information relating to my dental claims. I hereby authorize payment of the dental benefits otherwise payable to me directly to Stephen J. Davis, D.D.S.
Signed_____ Date_____

MEDICAL HISTORY

Name of your general physician:		Your Doctor's Phone No.:	
Your Doctor's Address:			

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Congenital heart lesions	☐ Liver disease
☐ Anemia	☐ Diabetes	☐ Pacemaker
☐ Anxiety/depression	☐ Emphysema	☐ Persistent cough
☐ Angina pectoris	☐ Epilepsy	☐ Psychological disorders
☐ Artificial heart valve	☐ Excessive bleeding	☐ Respiratory problems
☐ Artificial joints	☐ Fainting/dizziness	☐ Rheumatic fever
☐ Arthritis	☐ Glaucoma	☐ Sickle cell disease
☐ Asthma	☐ Heart disease/attack	☐ Sinus problems
☐ Blood disease	☐ Heart murmur	☐ Stroke
☐ Bruise easily	☐ Hemophilia	☐ Tuberculosis
☐ Cancer	☐ Hepatitis A, B, C, D, E	☐ Tumors
☐ Chemotherapy/radiation therapy	☐ High blood pressure	☐ Ulcers
☐ Cold sores/fever blisters	☐ Kidney disease	☐ Venereal disease (STDs)
Are you pregnant? ☐ Yes ☐ No **If yes, how many weeks and due date?**		

Have you had any serious illnesses in the last 2 years? If yes, please provide more information.	
Are you currently taking any medication or other pills regularly? If yes, please provide more information.	
Do you have any allergies of any kind? If yes please provide more information.	
Is your blood pressure normal, high or low?	
Do you use tobacco or alcohol? If so how often?	

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (Please circle as many as apply):

Sensitivity to hot or cold/when eating	food trapping between your teeth	clicking/pain in the jaw joints
Staining of your teeth	discolored fillings	roughness of existing fillings
Bleeding gums	bad breath	grinding/clenching of your teeth

What is the main purpose of your visit today?_____
_____

When was your last dental visit?_____

Is there anything about Dental Treatment make you nervous?_____
_____

Do you require medication before or during your appointment? _____

I certify that the above information is accurate. Signed _____Date_____