



# Benjamin L. Young, DDS, PC

10011 S. Centennial Parkway Suite 525 Sandy, UT 84070

801-352-8288

General and Cosmetic Dentistry

www.drbenyoung.com

Please fill out these forms as completely as possible. If you have any questions or need assistance please ask a staff member. We will be happy to help you.

Patient's name _____	Preferred Name _____
Date of birth ____/____/____	Marital Status _____
Home address _____	Zip code _____
Home phone _____	Cell phone _____
Social Security # _____	E-mail _____
How did you hear about our office? _____	
Occupation _____	Work Phone _____
Employer _____	May we call you at work if needed? Yes No
Emergency Contact _____	
Relationship _____	Phone _____

## RESPONSIBLE PARTY/INSURANCE INFORMATION

(If same as above, list "Same")	
Name of Account Holder _____	SSN or ID# _____
Date of birth ____/____/____	Group or Policy # _____
Insurance Carrier _____	
Insurance Carrier Phone Number _____	
As a service to you, your insurance will be billed with your consent upon signing this form.	

Please be advised of the following financial, insurance, and privacy policies:

- ***If you have dental insurance:*** The responsible party is accountable for all dental bills in our office. Our staff will help with completion and submission of primary insurance forms as an accommodation and convenience to you. It is the patient's responsibility to know their insurance benefits, assure collection of insurance payments, and to negotiate with the insurance company over any disputed claims. Some insurance policies may allow, but do not cover certain procedures such as lab fees and/or diagnostic tests. Any co-payments are due at the time of the appointment unless other arrangements have been made. Some insurance policies allow for an alternate benefit on selected procedures. In the event of such, the patient is responsible for any difference in allowable co-pay. Many insurance carriers do not cover cosmetic procedures; if this is the case the patient is responsible for the full payment of these services. We may be able to assist you with any questions; please don't hesitate to ask.
- ***If you have a secondary insurance policy:*** After we receive payment from the primary insurance carrier, we will provide you with a claim to submit to your secondary insurance (be sure to include a copy of the EOB from your primary insurance carrier). The balance remaining after the primary insurance has paid is your responsibility. If you have any questions in dealing with your insurance company, please contact our office for assistance.
- ***Health Insurance Portability and Accountability Act of 1996:*** This office is in compliance with regards to the electronic submission of patient information to third party payers. All patient records are maintained on a secured database with access by employees of Benjamin L. Young, DDS, PC only.
- ***If you do not have insurance:*** Payment in full is expected at time of service or advance financial arrangements must be arranged.
- ***Forms of payment:*** We accept payments in cash, check (with a guarantee card), money order, or most major credit cards. We can also assist you in applying for health care credit through a third party program.
- ***The responsible party agrees to:***
  1. Pay the doctor at the time service is rendered.
  2. Pay 2% per month (24% annually) on the unpaid balance with a minimum charge of \$2.00 repeat billing fee per month on balances over 60 days.
  3. Cover the balance of this account within 60 days from the date of service in the event the insurance company does not pay the entire balance within that time.
  4. Returned check fee of \$25.00, or the maximum allowable by law.
  5. Should the account be turned over for collection the undersigned shall pay reasonable attorney's fees, court costs and any collection costs up to 40%, with or without suit.
  6. Unpaid accounts over 90 days may be subject to collection fees.
  7. Pay a fee for failing to keep an appointment or canceling with less than 24 hours notice.

**Notice of Privacy Practices**

**Purpose:** This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. In addition to receiving a written copy of this Notice, it may be viewed online at [www.drbenyoung.com/privacy.htm](http://www.drbenyoung.com/privacy.htm)

I agree to the Financial Policy of this office and have read the privacy policy.

---

Signature

---

Date

# MEDICAL HISTORY

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_

**Please answer the following questions as completely as possible (circle "YES" or "NO")**

1. Are you now or have you been under a physician's care within the past year? YES NO  
If yes, specify condition being treated \_\_\_\_\_
2. Do you take any medications, including birth control pills or health supplements? YES NO  
Please specify name and purpose of medications: \_\_\_\_\_  
\_\_\_\_\_
3. Women: Are you pregnant? YES NO
4. Have you had a total joint replacement? YES NO
5. Do you have or have you ever had any heart or blood problems? YES NO
6. Do you have or have you ever had high blood pressure? YES NO
7. Do you require antibiotic pre-medication for a heart condition or artificial valve? YES NO
8. Have you ever taken Fosamax, Boniva, or another drug for osteoporosis? YES NO
9. Have you ever had hepatitis or liver disease? YES NO
10. Have you ever been diagnosed as being HIV positive or having AIDS? YES NO
11. Have you ever had (check any that apply):  
asthma \_\_\_\_\_ any blood disorder \_\_\_\_\_ tuberculosis \_\_\_\_\_  
diabetes \_\_\_\_\_ arthritis \_\_\_\_\_ heart attack \_\_\_\_\_  
kidney disease \_\_\_\_\_ immune system disorders \_\_\_\_\_ other disease \_\_\_\_\_
12. Have you ever had an unusual reaction to, or are you allergic to any of the following drugs:  
Penicillin \_\_\_\_\_ Aspirin \_\_\_\_\_ Acetaminophen \_\_\_\_\_ Sulfa Drugs \_\_\_\_\_  
Ibuprofen \_\_\_\_\_ Codeine \_\_\_\_\_ Other \_\_\_\_\_
13. Are you subject to fainting? YES NO
14. Are you allergic to any local anesthetic? YES NO
15. Do you use tobacco (smoke/smokeless)? YES NO
16. Do you have any other allergies? If yes, please describe: \_\_\_\_\_
17. Have you ever had a nervous breakdown or undergone psychiatric treatment? YES NO
18. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? YES NO
19. Do you have bleeding or sensitive gums? YES NO
20. If you are now in any dental pain, please explain: \_\_\_\_\_  
\_\_\_\_\_
21. When was your last dental visit? \_\_\_\_\_
22. Who was your previous dentist? \_\_\_\_\_
23. Are you interested in whitening your teeth in the near future? YES NO
24. Do you have any questions or concerns you would like to speak to Dr. Young about (crooked or chipped teeth, smile design, bad breath, frequent cold sores, gaps between teeth, etc)? \_\_\_\_\_  
\_\_\_\_\_

**I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical and dental status. I authorize Dr. Benjamin Young and/or assistants 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. 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 do voluntarily assume any and all possible risks, 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 any foregoing procedures will be explained to me if necessary and I will be given the opportunity to ask questions. I understand that any pictures/images taken may be used for educational and/or promotional use.**

Signature \_\_\_\_\_  
(Patient, legal guardian or authorized agent of patient)

Date \_\_\_\_\_