Dr. Steven Utecht, D.D.S.

Acknowledgement of Receipt Of
Notice of Privacy Practices
You may refuse to Sign This Acknowledgement

I, _____ have received a copy of Dr. Steven Utecht Notice of Privacy Practices.

_____

Please Print Name

_____

Signature/Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)

_____

_____

_____

Please list below anyone that you will allow us to discuss this account with:

1) _____

2) _____

3) _____

Insurance Information

Primary Medical Insurance Information

Name of **primary** subscriber:_____ _____
(first) (last)
Date of birth of **primary** subscriber: _____
Subscriber's social security number:_____
Address of subscriber if different from patient:
_____
City:_____State:_____ Zip:_____
Subscriber's employer:_____
Name of Medical Insurance: _____
ID #:_____

Primary Dental Insurance Information

Name of **primary** subscriber:_____ _____
(first) (last)
Date of birth of **primary** subscriber: _____
Subscriber's social security number:_____
Address of subscriber if different from patient:
_____
City:_____State:_____ Zip:_____
Subscriber's employer:_____
Name of Dental Insurance: _____
ID #:_____

Secondary Medical Insurance Information

Name of **secondary** subscriber:_____ _____
(first) (last)
Date of birth of **secondary** subscriber: _____
Subscriber's social security number:_____
Address of subscriber if different from patient:
_____
City:_____State:_____ Zip:_____
Subscriber's employer:_____
Name of Medical Insurance: _____
ID #:_____

Secondary Dental Insurance Information

Name of **secondary** subscriber:_____ _____
(first) (last)
Date of birth of **secondary** subscriber: _____
Subscriber's social security number:_____
Address of subscriber if different from patient:
_____
City:_____State:_____ Zip:_____
Subscriber's employer:_____
Name of Medical Insurance: _____
ID #:_____

3) IS THERE ANY ADDITIONAL INSURANCE? _____

SIGNATURE AUTHORIZATION FORM

1. I authorize the release of any medical information necessary to process my insurance claim(s) and request payment of benefits directly to Dr. Steven Utecht for services rendered.
2. I understand that the providers' charges may exceed my insurance company's payment. I, as the guarantor of my account, will be financially responsible for any unpaid balances.
3. I understand that there will be a returned check fee charged to my account should any personal check used for payment on my account be returned for any reason.
4. I understand that it is the office policy of Dr. Steven Utecht that the parent/guardian who brings in an underage child is the guarantor of the account and is financially responsible for any billing, regardless of divorce decrees or other arrangements made in a divorce situation.
5. **Refunds**: I understand that in the event of an overpayment, a refund check will be issued to the guarantor of the patient account.

BY SIGNING BELOW I HAVE READ AND UNDERSTAND THE STATEMENTS ABOVE.

X_____Date_____
Patient or guardian signature

Print Patient Name: _____

Patient Information Form

Dr.☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐

Patient's full name: _____ _____ _____ **Nickname:** _____
(first) (m.i.) (last)

Gender (please check) Female☐ Male☐ **Birth date:** _____ **Age:** _____ **Patient's Social Security #:** _____

Home address: _____

City: _____ **State:** _____ **Zip:** _____

Home ( ) _____ **Cell** ( ) _____ **Work** ( ) _____

Email address: _____ **Other number** ( ) _____

Name of patient's employer and/or school: _____ _____
(employer name) (school name)

Employer/Schools address: _____ _____ _____ _____ _____
(employer address) (school address) (city) (state) (zip)

Name of spouse/parent/guardian: _____

Emergency contact/Number: _____ (_____)_____

How did you hear about us? _____

Name of Dentist/Office location (if different from above): _____ _____ _____
(first) (last) (office location)

Name of other Dental Specialist/Office location: _____ _____ _____
(first) (last) (office location)

Name of family Physician/Office location: _____ _____ _____
(first) (last) (office location)

Phone #: ( ) _____ Have you seen your family physician during the past year and why? Y___ N___

_____

Have you ever had or have the following? ***Check Yes or No***

Y___ N___ Heart Murmur	Y___ N___ Rheumatic Fever	Y___ N___ Mitral Valve Prolapse (MVP)
Y___ N___ Heart Disease/Attack	Y___ N___ Chest Pains	Y___ N___ High Blood Pressure (HBP)
Y___ N___ Diabetes	Y___ N___ Blood Disease	Y___ N___ Porphyria (blood disorder)
Y___ N___ Tuberculosis (TB)	Y___ N___ Chemo/Radiation Therapy	Y___ N___ Hepatitis
Y___ N___ Blood Thinners	Y___ N___ Immune Compromise	Y___ N___ Stroke
Y___ N___ Alcohol Dependency	Y___ N___ Drug Dependency	Y___ N___ Kidney Disease
Y___ N___ Liver Disease	Y___ N___ Asthma/Bronchitis	Y___ N___ Contact Lenses
Y___ N___ Convulsions/Seizures	Y___ N___ Cortisone/Steroids	Y___ N___ Smoker/Tobacco frequency: _____

Y___ N___ Have you, or are you currently taking **Fosamax, Fosamax+D, Actonel, Actonel+Ca, Skelid, Didronel, Boniva, Reclast, Aredia, Zometa or any other bisphosphonate** medication (osteoporosis or cancer treatment medication)? (please circle)

Y___ N___ Any other operations? Explain: _____

Y___ N___ Cancer? Explain: _____

Y___ N___ Are there any other medical conditions we need to be aware of? Explain: _____

Are you **ALLERGIC to LATEX**? Y ____ N ____ Do you have any **ALLERGIES TO ANY MEDICATIONS?** Y ____ N ____

If yes, please list and note reaction to medication at that time:

Are you taking any **Over the Counter or Prescription medications**? Y ___ N ___ **Please list all medications & dosage amounts that you are taking**: ex- Motrin 600 mg 3 times a day (May write on back if not enough room)

WOMEN ONLY! For the following 3 questions, are you:

Y___ N___ Breast Feeding Y___ N___ Taking Birth Control medication Y___ N___ Pregnant, trimester _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

X_____ Date _____
Signature of patient/parent/guardian