DATE _____

Hugh J. Howard D.D.S.

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(435) 635-4244 • www.hughhowarddds.com
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PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____ Birthdate _____
(check all that applies) Sex: □ Male □ Female □ Minor □ Single □ Married
Street Address _____ City _____ State _____ Zip _____
E-Mail _____ For future appt. reminders, I prefer to be notified via □ text □ email □ phone call
Cell Phone _____ Home Phone _____ Work Phone _____
Employer _____
Driver's License Number _____ State _____ Social Security Number _____
Whom may we thank for referring you to our office? _____
In case of emergency, who should be notified?
Name _____ Phone _____ Relationship to Patient _____
Payment Method □ Cash □ Credit Card/Debit Card □ Care Credit □ Check I _____
hereby authorize assignment of my insurance rights and benefits directly to Hugh J. Howard D.D.S. for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

PERSON RESPONSIBLE FOR THIS ACCOUNT

□ Check here if address is the same as above
(If patient is a minor under 18, please complete the next section for the child's parent/guardian)
Name _____ Relationship to Patient _____ Birthdate _____
Home Address (if different from above) _____
Employer _____ Social Security Number _____ Driver's License Number _____
Payment Method □ Cash □ Credit Card /Debit Card □ Care Credit □ Check I _____
hereby authorize assignment of my insurance rights and benefits directly to Hugh J. Howard D.D.S. for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

INSURANCE INFORMATION

Dental Insurance _____ Yes _____ No Effective Date _____
Subscriber's Name _____
Subscriber's Birthdate _____ Member SS# _____
Subscriber's Employer _____
Insurance Company _____ Insurance Phone Number _____
Group Number _____ Member ID#/ _____

SECONDARY INSURANCE INFORMATION

Dental Insurance _____ Yes _____ No Effective Date _____
Subscriber's Name _____
Subscriber's Birthdate _____ Member SS# _____
Subscriber's Employer _____
Insurance Company _____ Insurance Phone Number _____
Group Number _____ Member ID# _____

DENTAL HISTORY

Approximate date of last dental appointment _____ Reason for first visit with us_____
Please add anything that you feel is important for the doctor to know_____

Please fill in the yes or no circle to the following questions:

o YES o NO Are you having PAIN, SWELLING, or SORE SPOTS at this time?
o YES o NO Do your GUMS BLEED?
o YES o NO Have you had PERIODONTAL TREATMENTS?
o YES o NO Do you have REMOVABLE dentures or partials? Upper _____ Lower _____
o YES o NO Is this your FIRST VISIT to any dentist?
o YES o NO Have you had any COMPLICATIONS with dental treatment?
o YES o NO Have you been treated for TMJ (Temporomandibular Joint problems)?
o YES o NO Do you have a FEAR of Dentistry? If yes, why? _____

MEDICAL HISTORY

Name of Your Primary Care Physician _____Phone _____Date of last physical _____
Are you taking any MEDICATIONS now (PRESCRIPTION AND/OR OVER-THE-COUNTER)? □ YES □ NO
If yes, please list _____

Women: Are you □ Pregnant/Trying to get pregnant? □ Nursing? □ Taking oral contraceptives?

Are you allergic to any of the following? □ **ACRYLIC** □ **ASPIRIN** □ **CODEINE** □ **LOCAL ANESTHETIC** □ **LATEX** □ **METALS** □ **PENICILLIN** □ **SULFA** □ **OTHER** _____
Are you currently taking Coumadin, Warfarin or other **BLOOD THINNERS**? □ YES □ NO_____

Do you have or have had at any time, any of the following?

□ Anxiety	□ Cold Sores	□ Hepatitis B	□ Radiation Treatments
□ Alzheimer's Disease	□ Diabetes	□ Hepatitis C	□ Rheumatic Fever
□ AIDS/HIV Positive	□ Drug Addiction	□ Herpes	□ Rheumatism
□ Anaphylaxis	□ Emphysema	□ High Blood Pressure	□ Scarlet Fever
□ Anemia	□ Epilepsy/Seizures	□ Hives or Rash	□ Shingles
□ Angina	□ Bleeding Problems	□ Hyperglycemia	□ Sickle Cell Disease
□Arthritis/Gout	□ Excessive Thirst	□ Hypoglycemia	□ Sinus Trouble
□Artificial Heart Valve	□ Fainting Spells	□ Irregular Heartbeat	□ Stomach/Intestinal Disease
□Artificial Joint	□ Frequent Cough	□ Kidney Problems	□ Stroke
□Asthma	□ Glaucoma	□ Leukemia	□ Thyroid Disease
□ Blood Disease	□ Hay Fever	□ Liver Disease	□ Tonsilitis
□ Breathing Problem	□ Heart Attack/Failure	□ Low Blood Pressure	□ Tuberculosis
□ Bruise Easily	□ Heart Murmur	□ Lung Disease	□ Tumors or Growths
□ Cancer	□ Heart Pace Maker	□ Mitral Valve Prolapse	□ Ulcers
□ Chemotherapy	□ Heart Disease	□ Pain in Jaw Joints	□ Venereal Disease
□ Chest Pains	□ Hepatitis A	□ Psychiatric Care	

Have you ever had any serious illness not listed above? □ Yes □ NO _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Hugh J. Howard D.D.S. of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Today's Date: _____

Hugh J. Howard D.D.S.

CONSENT TO PROCEED

I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE

**** I understand and agree that, regardless of my insurance status, I am ultimately responsible forthe balance on my account, for any professional services rendered and any subsequent finance charges applied to ageing accounts.I also agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee of 40% if my account is assignedto a collection agency.

I authorize Dr. Hugh J. Howard and/or associates or assistants as he/she 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, therapeuticor 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, temporary or rarely, permanent numbnessnd muscle soreness. 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 dentaltreatment, 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. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

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 beingaken 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 nonhealing 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 obtainingthe 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 th opportunity to ask questions.

Signature:_____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Witness:_____ Date: _____

(Rev. 11/11)