**Dane Nelson, D.M.D. • Wes Tillmann, D.M.D.• Ruedi Tillmann, D.D.S.**
5888 South 900 East, Suite 101 • Salt Lake City, Utah 84121 • 281-8433 • nelsontillmanndental@gmail.com

## 1 PATIENT INFORMATION

Date________________________________________________
SS/SSN# ____________________________________________
Patient Name ________________________________________
Last Name
____________________________________________________
First Name Middle Initial
Address ____________________________________________
City ________________________________________________
State ___________________________Zip________________
Email _______________________________________________
Sex: ☐ M ☐ F Age ________________
Birthdate ____________________________
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered
Patient Employer______________________________________
Employer Address _____________________________________
____________________________________________________
Employer Phone (______)______________________________
Spouse's/Parent Name _________________________________
Birthdate ___________________________________________
SS#________________________________________________
Spouse's/Parent Employer ______________________________

Whom may we thank for referring you to our practice?
☐ Another patient ☐ Dental Office ☐School ☐Work ☐Online
☐ Other______________
Name of person or office referring you to our practice:

## 2 DENTAL INSURANCE

List person responsible for Payment _________________________
Relationship to Patient ____________________________________
Primary Insurance Co. _____________________________________
Subscriber Birthdate ______________SS#___________________
Subscriber ID # __________________________________________
Group # _______________________________________________
Mailing Address __________________________________________
Phone # _______________________________________________
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name_________________________________________
Subscriber Birthdate______________ SS# __________________
Secondary Insurance Co. ___________________________________
Subscriber ID# ___________________________________________
Mailing Address___________________________________________
Phone # _______________________________________________
Group # _______________________________________________
Relationship to Patient ____________________________________

**ASSIGNMENT AND RELEASE**

I, certify that I and or my dependent(s) have insurance coverage with the above stated insurance companies and assign directly to,

Nelson/Tillmann Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

## 3 PHONE NUMBERS

Home (_____)________________ Work (_____)__________________ Ext. ___________ Cell Phone (_____)______________________

Spouse's/Parent Work (_____)___________________________________Best time and place to reach you__________________________

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name _______________________________________________ Relationship _____________________________________

Home Phone (_____)_____________________________________ Work Phone (______)___________________________________

## 4 DENTAL HISTORY

Reason for today's visit ________________
________________________________________
Former Dentist_____________________
City/State ________________________
Date of last dental visit_________________
Date of last dental X-rays_______________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| Condition | Yes | No |
|---|---|---|
| Bad breath | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No |
| Burning sensation on tongue | ☐ Yes | ☐ No |
| Use of Tobacco Products,Vaping | ☐ Yes | ☐ No |
| Cigarette, pipe or cigar smoking | ☐ Yes | ☐ No |
| Clicking or popping jaw | ☐ Yes | ☐ No |
| Dry mouth | ☐ Yes | ☐ No |
| Fingernail biting | ☐ Yes | ☐ No |
| Food collection between the teeth | ☐ Yes | ☐ No |
| Foreign objects | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No |
| Gums swollen or tender | ☐ Yes | ☐ No |
| Jaw pain | ☐ Yes | ☐ No |
| Lip or cheek biting | ☐ Yes | ☐ No |
| Loose teeth or broken fillings | ☐ Yes | ☐ No |
| Mouth breathing | ☐ Yes | ☐ No |
| Mouth pain, brushing | ☐ Yes | ☐ No |
| Orthodontic treatment | ☐ Yes | ☐ No |
| Pain around ear | ☐ Yes | ☐ No |
| Periodontal treatment | ☐ Yes | ☐ No |
| Sensitivity to cold | ☐ Yes | ☐ No |
| Sensitivity to heat | ☐ Yes | ☐ No |
| Sensitivity to sweets | ☐ Yes | ☐ No |
| Sensitivity when biting | ☐ Yes | ☐ No |
| Sores or growths in your mouth | ☐ Yes | ☐ No |

How often do you floss?_______________
How often do you brush?______________

Chart#____________________
FOR OFFICE USE ONLY

## 5 HEALTH HISTORY

Patient's Name______________________________ DOB______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionamin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| Condition | Yes | No |
|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No |
| Arthritis, Rheumatism | ☐ Yes | ☐ No |
| Artificial Heart Valves | ☐ Yes | ☐ No |
| Artificial Joints | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No |
| Bleeding abnormally, with extractions or surgery | ☐ Yes | ☐ No |
| Blood Disease | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No |
| Chemotherapy | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No |
| Congenital Heart Lesions | ☐ Yes | ☐ No |
| Cortisone Treatments | ☐ Yes | ☐ No |
| Cough, persistent or bloody | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No |
| Fainting or dizziness | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |
| Heart Murmur | ☐ Yes | ☐ No |
| Heart Problems | ☐ Yes | ☐ No |
| Hepatitis Type___________ | ☐ Yes | ☐ No |
| Herpes | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No |
| Jaundice | ☐ Yes | ☐ No |
| Jaw Pain | ☐ Yes | ☐ No |
| Kidney Disease | ☐ Yes | ☐ No |
| Liver Disease | ☐ Yes | ☐ No |
| Low Blood Pressure | ☐ Yes | ☐ No |
| Mitral Valve Prolapse | ☐ Yes | ☐ No |
| Nervous Problems | ☐ Yes | ☐ No |
| Pacemaker | ☐ Yes | ☐ No |
| Psychiatric Care | ☐ Yes | ☐ No |
| Radiation Treatment | ☐ Yes | ☐ No |
| Respiratory Disease | ☐ Yes | ☐ No |
| Rheumatic Fever | ☐ Yes | ☐ No |
| Scarlet Fever | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |
| Sinus Trouble | ☐ Yes | ☐ No |
| Skin Rash | ☐ Yes | ☐ No |
| Special Diet | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Swollen Feet or Ankles | ☐ Yes | ☐ No |
| Swollen Neck Glands | ☐ Yes | ☐ No |
| Thyroid Problems | ☐ Yes | ☐ No |
| Tonsillitis | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No |
| Tumor or growth on head or neck | ☐ Yes | ☐ No |
| Ulcer | ☐ Yes | ☐ No |
| Venereal Disease | ☐ Yes | ☐ No |
| Weight Loss, unexplained | ☐ Yes | ☐ No |

Do you wear contact lenses? ☐ Yes ☐ No

**Women:**

Are you pregnant? ☐ Yes ☐ No

Due date________________________

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

## MEDICATIONS

List medications you are currently taking and the correlating diagnosis:

_______________________________________________

_______________________________________________

Pharmacy Name ___________________________________

Phone (_______)___________________________________

## ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _______________

_______________________

## 6

Health Questionnaire acknowledgement and consent to proceed. I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment. I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Nelson/Tillmann Dentistry and/or such associates or assistants as they 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, therapeutic or 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, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

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 obtaining the potential desired results, which may or may not be achieved, for my 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 the opportunity to ask questions.

Signature______________________________________________ Date____________________
(patient or legal guardian of patient)

Witness ______________________________________________ Date____________________

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature ______________________________________________ Date____________________
(parent or legal guardian of patient)

Witness ______________________________________________ Date____________________

# Nelson & Tillmann Family Dentistry
## Office Financial Policy

***Ruediger Tillmann D.D.S., Wesley Tillmann D.M.D., Dane Nelson D.M.D.***
***5888 South 900 East, Ste. 101***
***Salt Lake City, Ut 84121***
***801-281-8433***

*In order to provide you with quality dental care the following financial policy applies.*

1. **Responsibility of Bill:** Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients and the patient is responsible to the doctor. **Any amount not covered by your insurance company is your responsibility**. We are happy to file your claims and assist you with the collection of any claims. If we do not receive payment from your insurance company in a timely manner we will re-file the claim and any balance will be your responsibility. You will need to contact your insurance company after that time.

2. **Acceptance of Insurance:** I agree to be responsible for all fees relative to the professional services rendered under this agreement, that this may include me, my family, or other individuals that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present, and future services rendered by the doctor and their staff to me, my family, or other individuals I have authorized. I recognize that insurance is a contract between the patient and the insurance company, and I agree that I will pay all charges under these agreements regardless of my insurance coverage. I may terminate my responsibility under this agreement by paying my account in full and giving written notice to the doctor.

3. **Time of Service Collections:** At the time of service we will estimate your patient portion of the charges. These charges **are** to be ***paid at the time of service.*** Payment options are: Check, Credit Card, and Cash. A 10% discount will be given to those patients who do not have insurance coverage and will need to be ***paid at the time of service.***

4. **Balance On Account:** A finance charge of 1 ½ % per month will be added to your bill if payment has not been received within 90 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction. Those patients who have two insurance plans may find that they have coordination of benefits clauses and may not cover your claims in full. Any amount not covered is your responsibility.

5. **Financial Responsibility of Divorced Parents:** *The parent who seeks medical care for the child is responsible for any unpaid amount.* Although divorced parents may have a divorce decree that establishes their financial responsibilities, we are NOT a party to the decree. We require the parent accompanying the child for treatment to accept primary responsibility for payment of those services. We will bill the parent who brought the child into our office for any unpaid amount. Any responsibility of the other parent, as set forth in the divorce decree, or implied or agreed upon by the parents, will be the responsibility of the parents and we will not be involved.

6. **Cancellation Policy:** I understand there will be a charge of $35 for any missed or cancelled appointment with less than 24 hours notice. This fee is your PERSONAL responsibility and not that of your insurance company. The Cancellation Policy also applies to appointments that have been made and then cancelled the same day.

7. **Release of Information**: By signing this form, you provide us with the authority to release such information as is necessary to collect from the insurance companies and other third party payers. You consent to receive calls from Tillmann Dental for your protected dental care and other services via any information given us by you (verbally or in writing). You may be charged for calls by your wireless carrier and such calls may be generated by an automated dialing system.

8. **Bad Debts/Collections/Legal Action:** Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

9. **Additional Lab Fee:** Some procedures that require comprehensive lab work and will be charged an additional lab fee: anterior crowns, gold crown, bridges, rush cases, implants, over dentures, or other work that requires a larger than usual lab fee.

Responsible party_______________________________________

Responsible party signature _______________________________

Family members & any other authorized patients_______________

Date____________________ Witnessed by____________________

# ACKNOWLEDGEMENT OF RECIEPT OF OFFICE PRIVACY POLICIES

**I, __________________________________________, have received a copy of**
**(Name of Patient, legal guardian or authorized representative)**

**this office's Privacy Policies.**

__________________________________________
**Print Name (Patient's Name)**

__________________________________________
**Signature (of patient, legal guardian or authorized representative)**

__________________
**Date**