**William C. Vargo D.D.S.**
Cosmetic & Family Dentistry
7138 South Highland Drive, Suite #219
Salt Lake City, Utah 84121

Phone : (801) 943-9090

Fax : (801) 943-2210

Patient Name: _____

Phone (Home) : _____ (Work) : _____ Birth Date: _____ Soc.Sec. # _____

Address: _____
Street City State Zip Code

***The following is for the financially (and insured if applicable) responsible party:***

Name: _____ Soc.Sec. # _____

Birth Date: _____ Self/Spouse/Parent/Other: _____

Phone (Home): _____ (Work): _____ (Pager): _____ (Cell) _____

Address: _____
Street City State Zip Code

Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

**Primary Insurance Information**: Name of Insured: _____ Birth Date: _____

Insurance Plan Name: _____ Phone # : _____

Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Phone # : _____

Soc Sec. # : _____ I.D.# _____ Group Plan #: _____

Relationship to Patient (Self/Spouse/Parent/Other): _____

**Do you have Secondary Insurance ?** ***Yes*** ***No*** (Please Circle)

**Referred to our office by** _____

## Consent for Services

All emergency dental services, or any dental services performed, must be paid for at the time that services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 18% per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements* are satisfied.

I understand that the fee estimate listed for this dental treatment is valid for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay , therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed. I further agree to pay all costs and reasonable attorney fees** if suit be instituted hereunder.

* Payment option plan- 90 days, same as cash on approved credit through WELLS FARGO FINANCIAL. Are you interested? *Yes* *No* (Please Circle)

** Our collection agency fee is 33% of the past due amount, for processing & collection of delinquent accounts.

I have read the above conditions of treatment and payment and agree to their consent.

Patient, Parent, or Guardian) Signature : _____ Date: _____

Witness Signature: _____ Date: _____

## Health Information

Name _____ Today's Date _____

General Heath: (Please Circle) *Excellent* *Good* *Fair* *Poor*

1. Reason for visit? _____
2. How long has it been since your last dental visit?

| *Yes* | *No* | |
|---|---|---|
| | | 3. Are you in pain now? Where? |
| ☐ | ☐ | 4. Are you aware of any dental problems? |
| ☐ | ☐ | 5. Are your teeth sensiti e? (Please Circle) *Cold* *Hot* *Sweets* *Pressure* |
| ☐ | ☐ | 6. Do you have bleedin gums? When? |
| ☐ | ☐ | 7. Are you pleased with he color of your teeth? |
| ☐ | ☐ | 8. We use local anesthe ia to control pain. We also use nitrous oxide analgesia to help relieve tension, fear, and anxiety. W uld you like to know more about this anesthetic? |
| ☐ | ☐ | 9. Are you aware of any lumps/bumps/swelling in your tongue/cheek/jaw/lips? |
| ☐ | ☐ | 10. Do you have proble s with food wedging between your teeth? |
| ☐ | ☐ | 11. Do you clench or gri d your teeth? When? |
| ☐ | ☐ | 12. Are you bothered by ad breath? |
| ☐ | ☐ | 13. Do you have or have had, any of the following problems? (Please Circle) |

| | | | | |
|---|---|---|---|---|
| Heart Condition | Kidney Problems | Heart Murmurs | Fainting Spells or Seizures | Stomach Ulcers |
| Abdominal Bleeding | Rheumatic Feve | High Blood Pressure | Heart Valve Replacement | Artificial Joints |
| Tuberculosis | Hepatitis A B C | Glaucoma | Any Allergies/Hay Fever/etc. | Latex Allergies |
| Diabetes | Rheumatism/Arthritis | Metal Allergies | Blood Disease, AIDS, HIV | Asthma or Sinus Trouble |

| | | |
|---|---|---|
| ☐ | ☐ | 14. Women : Are you pr gnant ? How many months ? _____ |
| ☐ | ☐ | 15. Are you now or have you been under the care of a physician during the past two years ? |
| ☐ | ☐ | 16. Have you ever had a allergic reaction to any medication, including penicillin, codeine, etc. ? (Please list) _____ |
| ☐ | ☐ | 17. Are you presently us ng any medication? (Please List) |
| ☐ | ☐ | 18. Are you subject to p olonged bleeding? |
| ☐ | ☐ | 19. Are you subject to n rvous disorders? |

**HEALTH QUESTIONNAIRE ACKNOWLEDGMENT & C NSENT 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 med tions can affect dental treatment. I understand the importance of and agree to notify Dr. Vargo of any changes at any subsequent appointment. I authorize Dr. William Vargo, an /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 mi or or other individual for which I have responsibility, including arrangement and/or administration of sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceut cal agent(s), including those related to restorative, palliative therapeutic or surgical treatments. I understand that the administration of local anesthesia may cause untoward rea tions 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 voluntaril assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general, preventative, operative treatment, and anesthesia dministration 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 at the nature and purpose of the forgoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature _____ Date _____

Witness Signature: _____ Date: _____