Marc A. Collman, DDS / Richard K. Wangsgard, DMD
2251 N 400 E, North Ogden, Ut 84414
801-782-9544 Fax: 801-786-0557

Patients Name:_____ **Date of Birth:** _____
How did you hear about our office?_____
Gender: M F Marital Status: _____
Birthdate: _____ Age: _____ **Social Security** #:_____ Drivers License :_____
Address:_____City:_____State: ____ Zip:_____
Email:_____ Email appt. reminder: Y N
Main Phone:_____ Cell:_____ Text appt. reminder: Y N
Employer:_____Occupation:_____ Work #:_____

Guarantor (or Responsible Party): Name:_____
Gender: M F Marital Status: _____
Birthdate: _____**Social Security** #:_____ Drivers License #:_____
Address:_____City:_____State: ____ Zip:_____
Email:_____ Email appt. reminder: Y N
Main Phone:_____ Cell:_____ Text appt. reminder: Y N
Employer:_____Occupation:_____ Work #:_____

Patient or Guarantor Spouse: Name:_____
Birthdate: _____**Social Security** #:_____ Drivers License #:_____
Email:_____
Main Phone:_____ Cell:_____ Work #:_____
Employer:_____Occupation:_____

Name of nearest relative not living with you:_____Phone:_____
Address:_____City:_____State: ____ Zip:_____

Insurance

Primary Dental Insurance: _____ **Policy Holder**:_____
ID #_____Group #_____
Insurance Address:_____City:_____State: ____ Zip:_____
Insurance Phone:_____ Effective Date: _____

Secondary Dental Insurance:_____ **Policy Holder**:_____
ID #_____Group #_____
Insurance Address:_____City:_____State: ____ Zip:_____
Insurance Phone:_____

Assignment of Benefits
I authorize payment of dental benefits to the named provider for professional services rendered.

Signed: _____Date_____

Insurance Release of Information
I authorize the release of any dental information necessary to process this claim.

Signed: _____Date_____

(Updated 2/2020)

(Please complete next pages)

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Medical History Form

Patient Name: _____ Birthdate: _____ Phone:_____
Medical Physician:_____ Office Phone #:_____
Dental Insurance: _____ ID #:_____

Y N **1**. Are you in good health? _____
Y N **2.** Are you allergic to any **drugs** or **medications**?_____
Y N **3**. Are you allergic to **metals** (gold, nickel, silver etc.)?_____
Y N **4.** Medications (name, strength, dosage) _____
_____
Y N **5.** Have you been told by another physician to pre-medicate before dental visits? _____
Y N **6.** Any previous hospitalizations? _____
_____

Please Circle

Anesthesia Reaction
Artificial Heart Valve
Blood Disease
Cough
Epilepsy
Heart Disease
Hemophilia
High Blood Pressure
Metal Allergy
Phen-Fen
Radiation Treatment
Seizures
Stroke
Tumors
Biophosphonate use
CPAP/BiPAP use

Angina
Artificial Joints
Cancer
Diabetes
Excessive Bleeding
Heart Failure
Hepatitis A
Kidney Disease
Mitra Valve Prolapse
Pacemaker
Pregnancy
Respiratory Problems
Sensory Impairment
Thyroid (hyper/hypo)
Ulcers

Aids
Arrhythmia
Asthma
Codeine Allergy
Drug/Alcohol Addiction
Fainting/Dizziness
Heart Murmur
Hepatitis B
Latex Allergy!!
Multiple Sclerosis
Penicillin Allergy
Pre-Medicate
Rheumatic Fever
Sinus Problems
Tobacco Use/ E-Cigs
Venereal Disease

Allergies
Arthritis
Autistic
Congenital Heart Lesions
Emphysema
Hay Fever
Heart Surgery
Hepatitis C
Liver Disease
Nervous Disorders
Periodontal Patient
Psychotic Treatment
Rheumatism
STD's
Tuberculosis
Yellow Jaundice

Y N 7. Do you have disease, condition or problem not listed above?_____
_____
Y N 8. Have you had any complications with any previous dental treatment? _____
_____
Y N 9. Have you ever had a reaction from dental anesthesia? _____
_____
Y N 10. Have you ever had prolonged bleeding from injury or previous extractions?_____
_____
11.When was your last dental exam? _____

WOMEN ONLY: Are you pregnant? Y N Nursing? Y N Taking Birth Control Pills? Y N

Patient Signature_____ Date_____ Reviewed By:_____

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HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED:

Patient Name: _____ Date of Birth:_____

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 appointments

I authorize Dr. Marc Collman and Dr. Richard Wangsgard 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 including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause a 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 occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative 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 tissue may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risk, 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 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 the opportunity to ask questions.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements signed and previously relating to financial arrangements or quality of care are null and void.

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. **All estimated copays and patient portions are due at time of service.**

Patients With Insurance:	Fillings	20%
	Crowns	50%
	Dentures	50%
	Implants	50%
	Root Canal Therapy	20%
Cash Only Patients:	Payment in full due at time of service.	

2. **We bill your insurance as a courtesy to you.** It is the patient's responsibility to follow up and make sure the insurance has paid in a timely manner. In the event your insurance does not pay, the balance of the account is your responsibility. We require the estimated patient portion to be paid before treatment. Please keep in mind this amount is an estimate only. You may or may not owe additional funds.
3. **Any amount left after insurance payment is due within 45 days** (60 days for Medicare patients) of receipt of statement. **A finance charge of 1 1/2**% per month (annual percentage rate 18%) of the unpaid balance will be added monthly ($1.00 minimum) **and a $25 per month late fee** will be added to your outstanding balance. Should collection become necessary, we may make a report to a credit bureau and/or use a collection agency and this may negatively impact your credit score. The responsible party agrees to pay a collection fee of up to 40% and all legal fees of collection, with or without suit, including attorney fees and court costs. **Please call our office for other payment arrangements if needed.**
4. **Any account referred to a collection agency will not be extended credit with our office from that time forward.** Patient will pay for any visit in full and then bill their insurance company at their convenience.
5. **The doctor/patient relationship will be canceled in the event of any of the following**: foul/ abusive behavior/language, nonpayment of account, multiple missed or cancelled appointments.
6. **48 HOURS ADVANCE NOTICE** must be given to cancel an appointment to avoid a **$35.00** missed appointment fee.
7. **In order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account including wireless telephone numbers.** We may also contact you via text message or email using any email address you provide us. Methods of contact may include pre-recorded/artificial voice and automatic dialing devices.

The undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing forty percent (40%) of the principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with collection action processing.

I have read and agree to all the above.

Print Responsible Persons Name_____

Responsible Person Signature_____Date: _____

Witness_____

COLLMAN WANGSGARD Dental

Richard K. Wangsgard, D.M.D.
Marc A. Collman, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME(S) _____

ADDRESS _____

PHONE _____ EMAIL _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT : By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, insurance billing and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you dec ide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your prote cted health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime by contacting:

CONTACT PERSON:	Dr. Richard Wangsgard
PHONE:	801-782-9544 FAX: 801-786-0557
ADDRESS:	2251 North 400 East North Ogden Utah 84414

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we t ook in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke th is Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Cons ent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, insurance billing and health ca re operations.

SIGNATURE _____ DATE_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

PERSONAL REPRESENTATIVE'S NAME _____

RELATIONSHIP TO PATIENT(S) _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Completed Consent will be in the patient's chart.