LLOYD K. LIU, D.M.D., P.C.
432 East 12300 South, Suite 8, Draper, UT 84020

Today's Date _____

PATIENT REGISTRATION AND ENROLLMENT

Patient Name _____ Date of Birth _____ Age _____

Gender: [ ] Male [ ] Female [ ] Other_____ Marital Status: [ ] Single [ ] Married [ ] Other_____

Address _____ City _____ State _____ Zip _____

Email Address _____ Primary Phone _____

Are you currently a full-time student? [ ] YES [ ] NO If yes, name of school _____

Driver's License # _____ State _____ Exp. _____ Social Security # _____

Employer Name _____ Date Employed _____ Occupation _____

Work Address _____ Work Phone _____

Best Method of Contact (please check all that apply) [ ] Primary Phone [ ] Text [ ] Work Phone [ ] Email

Best Time to Contact [ ] AM [ ] PM

RESPONSIBLE PARTY

Full Name _____ Relationship to Patient _____ Date of Birth _____

Gender: [ ] Male [ ] Female [ ] Other_____ Marital Status: [ ] Single [ ] Married [ ] Other_____

Address _____ City _____ State _____ Zip _____

Email Address _____ Primary Phone _____

Driver's License # _____ State _____ Exp. _____ Social Security # _____

Employer Name _____ Date Employed _____ Occupation _____

Work Address _____ Work Phone _____

Best Method of Contact (please check all that apply) [ ] Primary Phone [ ] Text [ ] Work Phone [ ] Email

Best Time to Contact [ ] AM [ ] PM

PRIMARY INSURANCE INFORMATION (If any)

Name of **Dental** Insurance Company _____ Employer _____

Policy Holder Name _____ Relationship to Patient_____

Date of Birth _____ Social Security # _____ Phone _____

Insurance Group # _____ Insurance Policy / Member ID # _____

SECONDARY INSURANCE INFORMATION (If any)

Name of **Dental** Insurance Company _____ Employer _____

Policy Holder Name _____ Relationship to Patient_____

Date of Birth _____ Social Security # _____ Phone _____

Insurance Group # _____ Insurance Policy / Member ID # _____

EMERGENCY CONTACT INFORMATION

Person to contact in case of emergency:

Name _____ Relation _____ Phone _____

Address _____ City _____ State _____ Zip _____

Person **not** within the same household to contact in case of emergency:

Name _____ Relation _____ Phone _____

Address _____ City _____ State _____ Zip _____

HOW DID YOU HEAR ABOUT US?

[ ] Friend/Family (**Name** _____) [ ] Insurance Co. [ ] Website [ ] Other _____

AUTHORIZATION AND RELEASE

I, hereby, authorize Dr. Lloyd K. Liu to release any information including the diagnosis and records of any treatment or examination rendered to me, or my dependents during the period of such dental care to third party and/or other health practitioners.

I, hereby, authorize assignment or payment of all dental and/or surgical benefits to which I or other family members (dependants) are entitled, including private dental insurance and other group health plan benefits, paid directly to Dr. Lloyd K. Liu, otherwise payable to me.

Signature _____ **Date** _____

(Patient, Parent, Legal Guardian or authorized agent of patient)

(Rev. 06/19)

METHOD OF PAYMENT

[ ] Cash [ ] Credit/Debit Card [ ] Care Credit

FINANCIAL POLICIES & FEDERAL TRUTH IN LENDING STATEMENT

Please be advised of the following office policies. Patient and responsible party agree to the following:

1. Payment in full is expected at the time of service unless a prior arrangement has been made and approved.
2. As a courtesy and service to you, if you carry dental insurance, we will file the insurance claims for you and will credit any such collections received, to the patient's account. However, you are personally responsible for any balance on your account not paid for or denied by your insurance carrier(s).
3. A 1.50% interest per month (annual rate of 18%) or a minimum charge on $1.00 will be charged to the unpaid balance after 60 days. The same will be applied to any unpaid balance on any prior financial arrangements after its agreed payment due date(s).
4. **If we do not receive at least 48 hours notice of your request to change your appointment, we reserve the right to assess a $25.00 broken appointment fee assessed for each ½ hour of your missed appointment.**

I/We agree to pay interest 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 if the account is assigned to a collection agency.

I/We grant my/our permission to you or your assignee to text messages, e-mails or telephone me/us at home or at my/our workplace(s) to discuss matters related to this form. You also acknowledge that such calls could result in charges to you by your telephone carrier.

I/We certify that I/We have answered all questions on this form accurately and to the best of my/our knowledge. I/We hereby agreed to abide by the conditions outlined hereon.

Signature _____ **Date** _____

(Patient, Parent, Legal Guardian or authorized agent of patient)

(Rev. 06/19)

Signature _____ **Date** _____

(Responsible Party)

(Rev. 06/19)

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ Phone: _____

Please answer ALL questions as completely as possible. (Circle **YES** or **NO**)

1. Do you consider yourself to be in good health? **YES** **NO**

2. Are you now or have you been under a physician's care within the past year? **YES** **NO**
If yes, specify the condition being treated _____

3. Do you take any medications, including birth control pills? **YES** **NO**
If yes, please specify name and purpose of medications _____
_____
_____

4. Do you have or have you ever had any blood or heart problems? **YES** **NO**

5. Have you ever been told that you have a heart murmur? **YES** **NO**

6. Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? **YES** **NO**

7. Do you have or have you ever had high blood pressure? **YES** **NO**

8. Do you bleed or bruise easily? **YES** **NO**

9. Have you ever been diagnosed as being HIV positive or having AIDS? **YES** **NO**

10. Have you ever had hepatitis or liver disease? If yes, please specify _____ **YES** **NO**

11. Have you ever had any of the following diseases? **YES** **NO**
(If yes, please **circle** any of the following that apply.)

Rheumatic fever	**Immune System Disorder**	**Venereal Disease**	**Asthma**
Heart Attack	**Any Blood Disorder**	**Diabetes**	**Rheumatism**
Arthritis	**Tuberculosis**	**Kidney Disease**	**Heart Disease**

Other diseases, please specify _____

12. Have you ever had an unusual reaction to or are you allergic to any of the following? **YES** **NO**
(If yes, please **circle** any of the following that apply.)

Penicillin	**Aspirin**	**Acetaminophen**	**Ibuprofen**	**Codeine**
Barbiturates	**Sulfa Drugs**	**Latex Rubber**	**Metals**	

Other allergies, please specify _____

13. Are you subject to fainting? **YES** **NO**

14. Have you ever had any severe reaction to dental treatment or local anesthesia? **YES** **NO**

15. Are you allergic to any local anesthetic? If yes, please specify _____ **YES** **NO**

16. Have you ever had any bad experience at a dental office? _____ **YES** **NO**

17. Have you ever had a nervous breakdown or undergone any psychiatric treatment? **YES** **NO**

18. Have you ever used or are you now using tobacco or alcohol? **YES** **NO**

19. Have you ever received counseling for use of alcohol and /or prescription drugs? **YES** **NO**

20. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? **YES** **NO**

21. **WOMEN:** Are you pregnant or nursing? **YES** **NO**

22. Are you in pain now? **YES** **NO**

23. How long ago did you last see a dentist? _____

24. Who was your previous dentist? _____

25. Do you think that your teeth are affecting your general health in any way? **YES** **NO**

26. Do you have or have you ever had bleeding or sensitive gums? **YES** **NO**
If yes, have you seen your physician or cardiologist for a cardiac evaluation? **YES** **NO**

27. Do you like the color of your teeth? **YES** **NO** Are you interested in teeth whitening? **YES** **NO**

I HEREBY CERTIFY THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature _____ **Date** _____
(Patient, Parent, Legal Guardian or authorized agent of patient)

CONSENT TO PROCEED

I authorize ***Dr. Lloyd K. Liu*** and/or such associates or assistants as s/he 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, muscle soreness, and temporary or rarely, permanent numbness. 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 dental treatment, 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. Dental materials and medications may trigger allergic or sensitivity reactions.

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 being taken 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 non-healing 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 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.

Signature _____ **Date** _____

(Patient, Parent, Legal Guardian or authorized agent of patient)

(Rev. 06/19)

Signature _____ **Date** _____

(Witness)

(Rev. 06/19)