Glenn L. Sands, D.D.S.
1770 E. Fort Union Blvd., Suite 201
Salt Lake City, Utah 84121

PATIENT INFORMATION

NAME _____ NICKNAME _____ ☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ MINOR
LAST FIRST M

ADDRESS _____
STREET APT# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME# WORK# PATIENTS CELL#

EMAIL ADDRESS _____

HOW WOULD YOU PREFER TO BE CONTACTED? PHONE _____ TEXT _____ EMAIL _____

PLACE OF EMPLOYMENT _____ SS# _____

DENTAL INSURANCE COMPANY _____ ID # _____ PHONE# _____

DENTAL INSURANCE COMPANY ADDRESS _____

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

HUSBAND (FATHER IF MINOR)

LAST	FIRST		M
STREET	CITY	STATE	ZIP
HOME TELEPHONE #		CELL #	
BIRTHDATE (MO/DAY/YEAR)		SS #	
EMPLOYER			
DENTAL INSURANCE CO.			GROUP #
DENTAL INSURANCE CO. POLICY HOLDER			

WIFE (MOTHER IF MINOR)

LAST	FIRST		M
STREET	CITY	STATE	ZIP
HOME TELEPHONE #		CELL #	
BIRTHDATE (MO/DAY/YEAR)		SS #	
EMPLOYER			
DENTAL INSURANCE CO.			GROUP #
DENTAL INSURANCE CO. POLICY HOLDER			

INSURANCE RELEASE AUTHORIZATION

I hereby authorize release of any dental treatment information to the above mentioned insurance company/ies for purposes of authorization and payment of dental treatment _____
Signed (Patient or Parent if Minor)

I hereby authorize insurance payment directly to Glenn L. Sands, D.D.S. _____
Signed (Patient or Parent if Minor)

PERSON RESPONSIBLE FOR ACCOUNT

Please Check one

☐ Patient ☐ Guardian
☐ Father (or Husband) ☐ Mother (or Wife)

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of immediate Family/Household
Name _____
Address _____
City/State/Zip _____
Telephone# _____

(Please continue on other side)

PATIENT'S NAME_____

(Please PRINT Clearly)

OFFICE FINANCIAL POLICIES

In accordance with the federal Truth in Lending Act, please be advised of the following office policies in connection with the extension of credit. By signing this agreement the responsible party agrees to:

1) Pay in full each time services are rendered unless other arrangements have been made. Cash, local checks with guarantee, Mastercharge, and Visa are accepted. As a courtesy to you, we will bill your insurance carrier, however, you are responsible for your entire bill. Any dispute which may arise with an insurance carrier over payment of a claim is the sole responsibility of the patient.

2) Pay 1.75% per month (21% APR) on any unpaid balance over 60 days past due, with a $3 minimum.

3) Pay a $40 fee on all returned checks.

4) Authorize a credit bureau report to be obtained when deemed necessary.

5) I grant my permission to you or your assignee to telephone me at my home or at my workplace to discuss matters related to my treatment or account.

I agree to pay the remaining balance due plus a 40% collection fee on my delinquent account if placed with a collection agency or attorney. I also agree to pay any court costs and reasonable attorney fees if my account is placed with or without suit.

X_____ Date_____

❑ *Adult Patient* ❑ *Father (or Husband)* ❑ *Mother (or Wife)* ❑ *Guardian*