Herriman Heights
DENTAL CARE

Patient Information

Patient Name: _____Preferred Name: _____

Date of Birth: _____Social Security #: _____ Male _____ Female _____

Status: Married ____Single ____Child _____ Divorced _____ Widowed _____ Other _____

Whom may we thank for your referral?

_____

Home Address: _____City: _____ Zip: _____
Cell: _____ Home: _____ Email: _____
Employer: _____ Phone: _____
Emergency Contact _____ Phone: _____

Responsible Party Name: _____ Date of Birth: _____

Relationship to Patient: _____Social Security #: _____ Phone: _____

Address: _____

Employer: _____Phone: _____

Primary Insurance

Insured name: _____Date of Birth: _____Relationship: _____

Insurance: _____ Employer: _____

Insurance address: _____

Phone: _____ ID # _____ Group # _____

Secondary Insurance

Insured name: _____ Date of Birth: _____ Relationship: _____

Insurance: _____ Employer: _____

Insurance address: _____

Phone: _____ ID # _____ Group # _____

Signature of Patient or Guardian _____ Date: _____

DENTAL HISTORY

Patient Name_____

Please check any of the following that apply to you currently:

□ Sensitivity (hot, cold, sweet etc.) □ Tooth pain or discomfort when chewing. □ Headaches, ear aches or neck pain.

□ Mouth ulcers or cold sores□ Jaw joint pain. □ Broken tooth or fillings. □ Grinding or clenching teeth □ Bleeding, swollen, or irritated gums □ Loose, tipped, or shifted teeth.

□ Bad breath or bad taste in your mouth. Other: _____

Please share the following dates:

Your last cleaning _____Your last oral cancer screening _____ Your last complete x-rays _____

Name of Previous Dentist: _____City: _____ State: ____ Phone Number: _____

Why did you leave previous dentist? _____

Do you smoke or use chewing tobacco? How much? For how long? _____

If you could change your smile, you would: _____

MEDICAL HISTORY

Please check any of the following that apply to you:

□ Allergies (seasonal) □ Anemia □ Artificial Heart Valve □ Artificial Joints□ Asthma □ Blood Disease □ Bruise Easily

□ Cancer □ Chemotherapy □ Diabetes □ Dizziness/Fainting □ Drug Addiction

□ Emphysema □ Excessive Bleeding □ Glaucoma □ Heart Conditions

□ Heart Murmur □ Hepatitis A □ Hepatitis B □ Hepatitis C

□ High Blood Pressure □ HIV/AIDS □ kidney disease □ Liver Disease

□ Mitral Valve Prolapse □ Anxiety □ Depression □ Pacemaker.

□ Radiation (head/neck) □ Respiratory Problems □ Rheumatic Fever

□ Scarlet Fever □ Seizures □ Stomach Problems □ Stroke

□ Thyroid Disease □ Tuberculosis □ Ulcers □ Other (please list): _____

For Women Only: □ Birth Control Pills □ Breast Feeding □ Pregnant _____

Are you currently under a physician's care? _____ If yes, Name of Physician: _____Phone: _____

Are you currently taking any medications? _____ If yes, for what? _____

What Medications are you currently taking? _____

Do you have any allergies to medications? ____ If yes, to what? _____

Are you allergic to Latex or metals? _____ Any other allergies? _____

I certify that I have read and understand the above and that the information given is an accurate and truthful health history.

Signature (parent or Guardian) _____ Date: _____

Riverton Heights DENTAL CARE

Office Financial Policies

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. Patients who carry dental insurance understand that all dental services furnished are charged to their dental insurance. The patient is responsible for paying the estimated co-payment at each dental appointment. This office will help prepare the insurance forms of our patients and assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render service on the assumption that our charges will be paid in full by an insurance company. A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service, unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I agree to pay the fees charged for the dental services provided to the dentist of his/her assignee at the time the services are rendered. I further agree to pay the remaining balance plus reasonable attorney fees, court costs, and a collection agency fee of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary. I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. I authorize the dentist and his assignees to release financial identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form to my insurance carrier or any related entities that require such information to be submitted. I acknowledge that I have read a copy of this office's privacy policies. I agree to disclose to the dentist names of any individuals whom I authorize the dentist to discuss my dental care.

•Riverton Heights Dental Care reserves the right to charge a $50.00 fee for any appointment cancelled without 48 hours' notice and a $25.00 fee for any returned checks.

•I acknowledge that treatment plans are **ESTIMATES ONLY** and are based on information given by my insurance company and me. All treatment costs remain my responsibility and I promise to pay my account, regardless of insurance coverage. If patient is 15 minutes late to his/her appointment, then appointment may have to be rescheduled. I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Signature of patient, parent, or guardian Date Relationship to patient

Riverton Heights DENTAL CARE

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Riverton Heights Dental Care, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of our services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member of another person responsible for your care. We may release some or all your health information when required by law.

If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Please give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change in your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (801)878-3111.

This notice goes into effect as of April 4, 2003.

Acknowledgment:

I have read a copy of this Notice of Privacy Practices.

Date: _____

Signed: _____Print Name: _____

If signing as a parent, guardian, please note the name of the patient:

_____

CONSENT TO PROCEED

I authorize Dr._____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. 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 reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental 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.

Patient Name:_____

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

Witness:_____ **Date:**_____