DESERET FAMILY DENTISTRY — PATIENT INFORMATION SHEET

Date		Referred By	

Patient Name		SSN		DOB		Age	
Address	Street Address, Apt # City State Postal Code			Email			
Home Phone		Mobile Phone		Sex	[ ] M [ ] F	Marital Status	
Employer		Phone		Occupation			
Student	[ ] Y [ ] N	Name of School					

Spouse Name		SSN		Occupation	
Employer		Phone			

Emergency Contact		Relationship	
Address	Street Address, Apt # City State Postal Code	Phone	

BILLING INFORMATION (IF DIFFERENT FROM ABOVE)

Billing Name		SSN		Relationship	
Address	Street Address, Apt # City State Postal Code				
Phone		Employer		Years Employed	
Employer Address	Street Address, Apt # City State Postal Code				
Employer Phone		Dental Insurance			

PRIMARY INSURANCE

Insured Name			
Social Security Number		DOB	
Relationship to Patient	[ ] Self [ ] Spouse [ ] Child [ ] _____		
Employer		Phone	
Insurance Company		Group #	
Claims Address	Street Address, Apt # City State Postal Code		

SECONDARY INSURANCE

Insured Name			
Social Security Number		DOB	
Relationship to Patient	[ ] Self [ ] Spouse [ ] Child [ ] _____		
Employer		Phone	
Insurance Company		Group #	
Claims Address	Street Address, Apt # City State Postal Code		

CONSENT TO PROCEED

I authorize Dr. Aaric J. Allred and/or such associates or assistants as 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 unwanted reactions 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.

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. After lengthy appointments, jaw muscles may also be sore or tender. 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, Actonel, may result in complications of nonhealing of the jawbones 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

_____ _____

Relationship to Patient Date

MINORS OR CHILDREN

Because _____, is a minor it is necessary that signed permission be obtained froma a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

_____ _____

Relationship to Patient Date

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

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 costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time 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 insurance forms of our patients or 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 services on the assumption that our charges will be paid in full by an insurance company.

I understand that I am required to give a 24 hour cancellation notice. If no notice is given there will be a $25 charge for the firswt missed appointment or late cancellation and a $50 charge for the second offense.if there is a third offense the patient will be placed in the inactive file.

A monthly service charge at a fixed rate of 18% per month* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) 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 (6) months from the date of the patient examination .

In consideration for the professional services rendered to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered , or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. 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.

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

I authorize the dentist or his designees to release financially 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 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

_____ _____

Relationship to Patient Date

DESERET FAMILY DENTISTRY — MEDICAL HISTORY

Patient Name		Date of Birth		[ ] Male [ ] Female	
Emergency Contact	Name of Relative or Person NOT LIVING with you	Phone Number		Relationship	
Address	Street Address, Apt #	City	State	Postal Code	

General Health	Good [ ] Fair [ ] Poor [ ]	Date of Last Physical		Physician's Name	

Please list all current medications

_____

_____

Are you allergic to any of the following medications?	[ ] Penicillin [ ] Codine [ ] Latex [ ] Local Anesthetics [ ] Sulfa Drugs
Please list any other allergies	_____

Please check all those that apply

- [ ] Need Antibiotic Coverage Prior to Dental Work
- [ ] Use or Have Used Tobacco Products in the Past
- [ ] Subject to Fainting
- [ ] High Blood Pressure
- [ ] Artificial Joint Replacement
- [ ] Subject to Prolonged Bleeding
- [ ] (WOMEN) Currently Pregnant (Months_____)
- [ ] Undergone Radiation or IV Chemotherapy
- [ ] Currently Taking or Have Taken Blood Thinners
- [ ] (WOMEN) Currently Nursing

Do you have or have you ever been diagnosed with any of the following?

- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Congenital Heart Defects
- [ ] Rheumatic Fever
- [ ] Abnormal Blood Pressure
- [ ] Stroke
- [ ] Cancer (Type:)
- [ ] Tuberculosis or Lung Disease
- [ ] Respiratory Disease
- [ ] Acid Reflux
- [ ] Epilepsy or Seizures
- [ ] Anemia
- [ ] Hemophilia
- [ ] Hepatitis (Type:)
- [ ] Kidney Disease or Dialysis
- [ ] Asthma or Hay Fever
- [ ] Osteoporosis
- [ ] Thyroid Disease
- [ ] Long Term Steroid Treatment
- [ ] Autoimmune Disorders
- [ ] AIDS/HIV
- [ ] Drug or Substance Addiction
- [ ] Eating Disorders
- [ ] Neck or Back Problems
- [ ] Glaucoma
- [ ] Diabetes (Type:)

Do you have any other medical or health conditions which are not listed	[ ] Yes [ ] No	
Have you ever been hospitalized for any serious illness, operation or surgery?	[ ] Yes [ ] No	
Have you ever taken Fosamax, Actonel, Boniva or any other drugs for osteoporosis or metastatic bone cancer?	[ ] Yes [ ] No	
Is there anything that you prefer to talk to the Doctor in private about?	[ ] Yes [ ] No	

Are you currently in pain?	[ ] Yes [ ] No	Are you unhappy with the appearance of your teeth or gums?	[ ] Yes [ ] No
Name of previous Dentist		Date of last Dental Visit	
Reason for today's visit?		How often do you brush?	
Have you ever had a serious problem associated with a previous dental treatment?	[ ] Yes [ ] No	Explain	

Check any of the following which apply to you

- [ ] Gums bleed during brushing or flossing
- [ ] Usually break fillings or teeth
- [ ] Regularly clench or grind your teeth
- [ ] Currently (or previously) used a mouthguard or splint
- [ ] Pain with brushing or flossing
- [ ] Pain with biting or chewing
- [ ] Bad odors or tastes in mouth
- [ ] Frequent cold sores, blisters or other oral/lip lesions
- [ ] Frequent sensitivity to cold, hot or sweets
- [ ] Jaws frequently feel tired or sore
- [ ] Jaw frequently pops or clicks
- [ ] Food frequently gets caught between teeth

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING 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, legal guardian or authorized agent of patient)

OFFICE PRIVACY POLICIES

INTRODUCTION:
This Notice describes the privacy policies of this dental office. First and foremost, we strive to maintain confidentiality as far as your dental treatment information. There are times, however, where identifiable health information must be disclosed to specific entities such as your insurance carrier. Herein we describe how this confidential dental and health information is used and disclosed and how you can gain access to this confidential information.

BACKGROUND INFORMATION:
Dental offices are required by applicable federal and state laws to maintain confidentiality of dental health information generated for patients during the course of treatment. Through recent legislation dental offices are now required to notify all patients about privacy practices. Our legal duties concerning these practices and your rights concerning your health information. These office privacy policies take effect as of April 14, 2003 and will remain in effect until amended by this office. We reserve the right to change the privacy practices of this office and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices effective for all health information that we collect and maintain, including prior dental information as well as information gathered before policy changes are determined to be necessary. As changes in our privacy practices are made, we will notify our patients of these changes and make amended Office Privacy Policy statements available upon request. Our patients are welcome to request copies of our office privacy policies at any time. Please keep this information on file with other documents from this office end check with our receptionist or office manager for any amended versions or changes.

USES AND DISCLOSURES OF HEALTH INFORMATION

This office uses and discloses health information about you and/or family members for purposes of treatment, payment and dental practice operations. For example:

TREATMENT: We may use or disclose your dental health information to dental colleagues, your physician or other health care providers rendering treatment;

PAYMENT: We may use and disclose your dental treatment information through regular mail, fax or electronic transmission to your dental insurance carrier to obtain payment for services rendered. Limited treatment information may also be disclosed to billing services which assist the office in preparing monthly billing statements.

DENTAL PRACTICE OPERATIONS: We may use and disclose your health information in conjunction with our health care operations, which include quality assessment and improvement activities, reviewing the competence or qualifications of personnel who work in this office, evaluating performance, conducting training programs within the office, accreditation, certification, licensing or credentialing activities. Your health information may also be disclosed to our attorneys and consultants as necessary to respond to any type of investigation or legal action pertaining to the quality of treatment provided to you.

YOUR AUTHORIZATION: in addition to our use of your health information for treatment, payment, or dental practice operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us such an authorization, you have the right to revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

DISCLOSURE TO FAMILY AND FRIENDS: You have the right for us to disclose your own personal dental health information to you as described in the Patient Rights section of our Privacy Policies. We may also disclose your dental health information to a family member, friend or other person to the extent necessary to help with your dental care or with payment for your dental care, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose dental health information to identify or assist in the identification of you or a family member in conjunction with a forensic investigation. In the event of your incapacity or in emergency circumstances, we will disclose health information based on our professional judgment. In that instance we will disclose only that information that is directly relevant to the treating entity's involvement in your health care. We will also use our professional judgment and experience to make reasonable inferences of your best interest in allowing a pension to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.

MARKETING: We will not use your dental health information or images of your face and/ or teeth for marketing communications without your specific written authorization to do so.

SUBPOENA: We may use or disclose your health information when we are required to do so by law through subpoena.

ABUSE OR NEGLECT: We may disclose dental information of minor patients to appropriate authorities if we have reason to believe that they are possible victims of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the dental health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials dental information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose dental information to correctional institution or law enforcement officials having lawful custody of protected dental information of inmates or patients under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose basic dental information insofar as the fact that you have a dental appointment scheduled in the form of appointment reminders such as voice mail messages, postcards, letters or e-mail messages.

MINIMAL NECESSARY DISCLOSURES: We will not make disclosures of your health information to a greater degree than we consider minimally necessary for the purpose of each disclosure.

PATIENT RIGHTS

ACCESS: You have the right to read over or obtain copies of your dental health information, with limited exceptions. Utah law (R-156-69-502(7) specifies that original records must remain in possession of the treating dentist for seven years, but you may request copies. You may request in person or in writing to obtain access to your dental information. You will be charged a reasonable cost-based fee for expenses such as copies and staff time. You will be asked to sign a brief authorization to obtain copies of your records, For written copies, you may be charged up to $0.75 for each page up to thirty (30) and $0.50 for each page after thirty, a $15.00 administrative fee to locate and copy your health information and postage if you want the copies mailed to you, Radiographs (x-rays) will be duplicated at a reasonable fee related to costs generated by this office to produce copies. Study models (dental casts) will also be duplicated for a reasonable fee related to costs of materials and time spent in duplicating the originals. Photographs and slides can also be duplicated at cost. If you prefer, we will prepare a summary or a written explanation of your health information for a fee related to the complexity of the summary. You may contact the privacy officer listed at the end of this Notice for a full explanation of our duplication fee structure.

DISCLOSURE FREQUENCY: You have the right to receive a list of instances in which this practice disclosed your dental information for purposes other than treatment, payment, dental practice operations and certain activities for the six month period starting April 15, 2003 and at any six month interval thereafter. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use of disclosure of your dental health information. We reserve the right to discuss your request and we are not required to agree to your additional restrictions. If we agree to abide by your request, however, we may be exempted from this agreement in the event of an emergency.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your dental health information by alternative means to alternative locations (fax or e-mail, for example). You must make your request in writing. Your request must specify the alternative means or location.

AMENDMENT: You have the right to request that we amend your dental health information that has been provided to you. Your request must be in writing and it must explain why the information should be amended. We reserve the right to deny your request under certain circumstances.

ELECTRONIC NOTICE: if you first reviewed our privacy policies on our web sties or by e-mail you are entitled to receive this Notice in written form upon your request.

QUESTIONS AND COMPLAINTS

If you want additional information about our privacy policies or have questions or concerns, you should contact our privacy officer listed below. If you believe or are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your dental health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also correspond with the U.S. Department of Health and Human Services. We will provide you with the address of the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your dental health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Office Privacy Officer: Jayne Radl
Office Telephone: (435)884-3088
Office Fax: (435)884-3086
Address: 225 East Main Street, Suite G
Grantsville, Utah 84029

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICIES

I, _____, have received a copy of this office's Privacy Policies.
Name (Please Print Legibly)

_____ _____
Signature Date