Canyon Dental Care

PATIENT INFORMATION

DATE _____

PATIENTS NAME _____ **DATE OF BIRTH** _____

PATIENTS SEX _____ **MARITAL STATUS** _____

ADDRESS _____ **CITY/STATE/ZIP** _____

HOME PHONE # _____ **CELL PHONE #** _____

SOCIAL SECURITY NUMBER _____ **EMAIL** _____

PATIENTS EMPLOYER _____ **WORK PHONE#** _____

EMERGENCY CONTACT _____ **CONTACT PHONE#** _____

EMERGENCY CONTACTS RELATIONSHIP TO PATIENT _____

WHO REFERRED YOU? internet insurance family/friend (list name): _____

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY _____

SUBSCRIBER NAME _____ **DATE OF BIRTH** _____

SUBSCRIBER EMPLOYER _____

SUBSCRIBER SOCIAL SECURITY # *or* ID NUMBER _____

GROUP NUMBER _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY _____

SUBSCRIBER NAME _____ **DATE OF BIRTH** _____

SUBSCRIBER EMPLOYER _____

SUBSCRIBER SOCIAL SECURITY # *or* ID NUMBER _____

GROUP NUMBER _____

MEDICAL HISTORY

PATIENT NAME:_____ DATE OF BIRTH:_____

PHYSICIAN'S NAME: _____ PHONE:_____

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 condition being treated		
3. Do you take any medications, including birth control pills?	YES	NO
Please specify name and purpose of medications:_____		
_____		
4. Do you have or have you ever had any heart or blood 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?	YES	NO
11. Have you ever had: rheumatic fever ;____ asthma ;____ any blood disorder ;____	YES	NO
diabetes ;____ rheumatism ;____ arthritis ;____ tuberculosis ;____ venereal disease ;____		
heart attack ____; kidney disease ;____ immune system disorders ; ____ other disease____ ?		
If so, specify:_____		
12. Have you ever had an unusual reaction or are you allergic to any of the following	YES	NO
drugs: Penicillin ;_____ Aspirin ;____ Acetaminophen ;____ Ibuprofen ;____		
Codeine ;____ Barbiturates ;____ Sulfa Drugs ;____ Other		
13. Are you subject to fainting?	YES	NO
14. Have you ever had any severe reaction to dental treatment or local anesthetics?	YES	NO
15. Are you allergic to any local anesthetic?	YES	NO
16. Do you have any other allergies? If Yes, please describe:_____	YES	NO
_____		
17. Have you ever had a nervous breakdown or undergone psychiatric treatment?	YES	NO
18. Have you ever received counseling for use of alcohol and/or prescription drugs?	YES	NO
19 Women: Are you pregnant?	YES	NO
20. Are you now in pain?	YES	NO
21. How long ago did you last see a dentist? _____		
22. Who was your previous dentist?		
23. Do you think that your teeth are affecting your general health in any way?	YES	NO
24. Do you have or have you ever had bleeding or sensitive gums?	YES	NO
25. Have you ever taken Phen-Fen or similar appetite suppressants?	YES	NO
If yes, have you seen your physician or cardiologist for a cardiac evaluation?	YES	NO
26. Have you ever used or are you now using tobacco or alcohol?	YES	NO
27. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease	YES	NO
the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?		

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) (Rev. 7/06)

Canyon Dental Care

CONSENT TO PROCEED

I authorize the dentists of Canyon Dental Care 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 authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

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.

Patient: _____

Signature: _____

(Patient, legal guardian or authorized agent of patient)

NOTICE OF PRIVACY PRACTICES ACKNOWLEGMENT

CANYON DENTAL CARE

291 S MAIN

SMITHFIELD, UTAH 84335

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPPA"), I have certain rights to privacy regarding my health information. I understand that this information can be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy* from time to time and that I may contact this organization at any time at the address above to contain a current copy of the *Notice of Private Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requests restrictions, but if you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Responsible Party (if patient is a minor)

Date: _____

Do we have permission to leave dental health information on your voicemail or with family members? YES/NO

Canyon Dental Care Financial Policy

Thank you for choosing Canyon Dental Care as your dental care provider. We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is necessary in order for us to provide treatment.

Patients with Dental Insurance

As a courtesy to our patients, we prepare and process all insurance forms. However, having insurance does not release the patient from responsibility. Our expectations of you as the owner of the policy are as follows:

1. Estimated patient portions must be paid at the time of service. This may include co-payments, deductibles, co-insurance and/or non-covered procedures.
2. You are responsible for educating yourself about the details of your policy which includes deductibles, yearly maximums, and policy exclusions.
3. If the insurance company does not pay our office within 60 days, it is your responsibility to pay using one of the payment methods listed below. The insurance policy belongs to you and we have no leverage to obtain payment.

A rebilling charge of 1.5% per month (annual percentage rate 18%) will be assessed on any unpaid balance over 60 (sixty) days regardless of insurance estimates. Insurance estimates are based on limited information provided to our office by your insurance company and is not a guarantee of coverage or payment.

Patients without Dental Insurance

If you have no insurance coverage, full payment is due at time of service with one of the payment options below:

Payment Options

For your convenience, you may choose any of the following methods of payment:

- Cash
- Personal Check , postdated if necessary (Returned check fee will be charged at $25 per check)
- Visa, MasterCard, Discover, American Express – Credit or Debit
- Extended Payment Plan with our Financing Partner, Care Credit. Short-term plans are available with no interest. Credit approval must be received PRIOR to treatment.

Broken & Missed Appointments

Please make every attempt to keep your scheduled appointments. If you must cancel or reschedule, kindly notify us at least 24 hours in advance. **There is a $37 charge for all appointments that are broken or missed** without a 24 hour notice.

Minor Patients

The parent, guardian or adult accompanying and signing all forms for a minor will be responsible for full payment. Parents or guardians must be present to authorize all dental treatment to minors.

Release of Information and Insurance Payment Authorization

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to the dentists at Canyon Dental Care.

Financial Agreement

I understand that I am financially responsible for all charges incurred by my dependents, or myself whether or not covered by insurance. I agree to pay Canyon Dental Care for professional services rendered to me at the time of service. If my insurance pays less than estimated, I agree to pay any remaining balance within 30(thirty) days of billing, I expressly agree to pay all costs of collection agency fees assessed at 40% of the total amount due, and all court costs and attorney fees, if these terms are not met.

Signature: _____

(Patient, legal guardian of authorized agent of patient)