Patient Registration and Medical History

FAMILY LEGACY DENTAL
845 NORTH 100 WEST
SUITE 100
OREM, UTAH 84057
OFFICE... 801-227-5080
FAX..... 801-227-7887

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Soc. Sec. #_____

Address _____ City _____ State_____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Spouse or Parent's Name _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Responsible Party

Name of Person Financially Responsible for this Account _____

Address _____ City _____ State_____ Zip _____

Relationship to Patient _____ Soc. Sec. # _____ Driver's License # _____

Home Phone _____ Email Address _____

Patient's or Parent's Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Dental Insurance Company _____

ID # _____ Group # _____

Ins Co Address _____ City _____ State_____ Zip _____

Ins Co Phone # _____ Employer _____

Employer Phone # _____ Name of Insured _____

Birthdate _____ Soc. Sec. #_____ Date Employed _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No **IF YES, COMPLETE THE FOLLOWING:**

Dental Insurance Company _____

ID # _____ Group # _____

Ins Co Address _____ City _____ State_____ Zip _____

Ins Co Phone # _____ Employer _____

Employer Phone # _____ Name of Insured _____

Birthdate _____ Soc. Sec. #_____ Date Employed _____

Alternative Contacts

1) Name of Individual _____ Phone # _____

Address _____ City _____ State_____ Zip _____

2) Name of Individual _____ Phone # _____

Address _____ City _____ State_____ Zip _____

How did you Hear About Our Office? (CHECK ALL THAT APPLY)

☐ Internet Search ☐ FamilyLegacyDental.com ☐ Medicaid Provider List ☐ Insurance Provider List

☐ Our Facebook Page ☐ Our Twitter Page ☐ Our Blog Page ☐ Phone Book ☐ Coupon in the Mail

☐ Movie Theater Ad ☐ Little Ad Magazine ☐ Hometown Values Magazine ☐ Valpak ☐ Mail Piece

☐ Google Places ☐ Google Maps ☐ KSL.com ☐ Info brought home from your child's school

☐ Referring Dr. (name)_____ Location _____

☐ Friend/Family (name)_____ (so we can personally thank them)

☐ Other _____ ☐ Other _____

Have you liked us on Facebook? ☐ Yes ☐ No (If not, please go to facebook.com/familylegacydental and like us)

Federal Truth-in-Lending Statement and Office Policies

As a condition of your treatment by this office, financial agreements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial agreements, must be paid for at the time services are rendered.

A service charge of 1.5% per month (18% annually) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist. I agree to pay the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected by me, in writing, within the time of payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable

attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% of principle) that may be assessed by any collection agency retained to pursue this matter.

I grant permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, Family Legacy Dental.

I certify that I have answered all the questions on the form accurately and I hereby agree to abide by the conditions outlined therein.

Appointment Time Policy

We ask that you allow up to two hours for your dental appointment. For example, if your appointment is scheduled for 8:00am, we will try to assure that you are out of the office by 10:00am. Usually your visit will require less than two hours. There are several reasons why we ask that you allow this flexibility:

- We do not rush exams or operative procedures and do not take shortcuts.
- We sometimes need to schedule a person who is in severe pain from a dental emergency.
- At times, exams are longer than expected due to the need to translate for the patient in a second language.
- Sometimes an operative procedure requires more time than expected.
- Sometimes patients require a longer period of time to anesthetize the tooth.

If, for any reason, your schedule does not allow this flexibility, please discuss this with the office manager.

Payment Policy

Payment is due at the time of service. If you have insurance that we accept, your estimated deductible and co-payment are due at the time of service. Co-pay estimates are subject to final approval by your insurance company; therefore, the co-pay due is subject to change. For children, the parent that accompanies the child is responsible for paying the fee.

I understand that my dental care insurance carrier of payer of my dental benefits may pay less than the actual bill for my services. I understand that I am financially responsible for payment in full of all accounts at the time of service. I understand that if my account is turned to a collection agency, 35% will be added to the balance of the account. I agree to pay all attorney and court fees from the resulting collection process. I agree to pay interest of 1.5% per month (18% per year) on all balances past due by 60 or more days.

Cancellation Policy

In order to keep our fees as low as possible and to minimize your waiting time, we request that you keep your appointment and arrive on time. However, if you need to reschedule, **please provide us with a 24 business hours notification in order to avoid a broken appointment fee of $25.00.**

Please indicate below with your signature that you have read these office policies and agree to abide by them.

Signature (Patient, Parent or Guardian) _____ Date _____

Relationship to Patient _____

Medical/Dental History Form (please read and answer the following questions)

Name of Patient _____

Name of Physician _____ Office Phone _____

Yes No

(Y) (N) 1. Are you having pain or discomfort at this time?
(Y) (N) 2. Do you have or have you ever had bleeding or sensitive gums?
(Y) (N) 3. Do you feel nervous about having dental treatment?
(Y) (N) 4. Have you been hospitalized during the past two years?
(Y) (N) 5. Have you been under the care of a medical doctor during the past two years? (if yes, complete the following)

Physician's Name _____ Type of Practice _____

Address _____ Phone _____

(Y) (N) 6. Have you taken any medication or prescription drugs during the past two years?
Are you currently taking any medication, prescription drugs or pills?
If yes, please list _____

7. Are you allergic or have you reacted adversely to any of the following?

☐ Aspirin	☐ Erythromycin	☐ Sulfa Drugs	☐ Barbiturates
☐ Codeine	☐ Penicillin	☐ Latex	☐ Nitrous Oxide
☐ Ibuprofen	☐ Tetracycline	☐ Acetaminophen	☐ Other Antibiotics
☐ Local Anesthetic	☐ Other _____		

8. Check any of the following which you **have had or have** at the present time

☐ Heart Murmur	☐ Other Heart Condition	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Artificial Joints (hip,knee)	☐ Anemia
☐ Stroke	☐ Kidney Disease	☐ Blood Disease	☐ Ulcers
☐ Cosmetic Surgery	☐ Drug Addiction	☐ HIV/AIDS +	☐ Any Venereal Disease
☐ Emphysema	☐ Hepatitis	☐ Tuberculosis	☐ Asthma
☐ Diabetes	☐ Respiratory Disease	☐ Sinus Trouble	☐ Hay Fever
☐ Liver Disease	☐ Tumors/Growths	☐ Chemotherapy	☐ X-ray or COBALT Treatment
☐ Rheumatism/Arthritis	☐ Glaucoma	☐ Pain in Jaw Joints	☐ Cold Sores
☐ Hemophilia	☐ Yellow Jaundice	☐ Psychiatric Treatment	☐ Sickle Cell Disease
☐ Bruise Easily	☐ Slow Healing	☐ Fever Blisters	☐ Epilepsy or Seizures
☐ Fainting or Dizzy Spells	☐ Other _____		

(Y) (N) 9. FEMALE: Are you pregnant or suspect that you may be pregnant?

(Y) (N) 10. Have you ever been told that you need to be pre-medicated for dental treatment?
If yes, explain why _____
(Y) (N) 11. Do you have pain in or near your ears?
(Y) (N) 12. Do you have any unhealed injuries or inflamed areas around your mouth?
(Y) (N) 13. Have you ever experienced any growth or sore spots in your mouth?
(Y) (N) 14. Does any part of your mouth hurt when your jaws are clenched?
(Y) (N) 15. Have you ever had anesthetic?
(Y) (N) 16. Have you ever had any reactions to anesthetic?
(Y) (N) 17. Have you ever had any difficult extractions or prolonged bleeding in the mouth?
(Y) (N) 18. Have you ever had trench mouth?
(Y) (N) 19. Have you ever had instructions on the proper care of your gums?
(Y) (N) 20. Do you chew on one side of your mouth only? If so, Why? _____
(Y) (N) 21. Do you, at the present time, have any dental complaints?
(Y) (N) 22. Do you habitually clench your teeth during the day or night?
(Y) (N) 23. When was your last full mouth X-ray taken? _____ Where? _____
(Y) (N) 24. Are any parts of your mouth sensitive to pressure,cold, sweets, etc.?
If so, Where? _____

Signature (Patient, Parent or Guardian) _____ Date _____

HIPAA Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____