Heritage Dental Associates

PATIENT INFORMATION

DATE

PATIENT'S NAME | BIRTHDATE | AGE

ADDRESS | CITY, ZIP

SEX ☐M ☐F | PATIENT'S SOC. SEC. NO. | MARITAL STATUS ☐M☐S☐C

PATIENT'S EMPLOYER | OCCUPATION

PATIENT'S HOME PHONE | WORK PHONE | CELL PHONE

PATIENTS EMAIL ADDRESS

PERSON TO CONTACT IN CASE OF EMERGENCY (Not currently living with you)

ADDRESS | CELL | PHONE

RELATIONSHIP TO PATIENT

WHOM MAY WE THANK FOR YOUR COMING TO OUR OFFICE OR WHERE DID YOU FIRST HEAR OF OUR OFFICE?

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME | BIRTHDATE

RESIDENCE ADDRESS | CITY, ZIP

HOME PHONE | SSN

EMPLOYER | EMPLOYER PHONE

EMPLOYER ADDRESS | CITY, ZIP

WILL DENTAL INSURANCE BE INVOLVED? | IF YES, PLEASE COMPLETE NEXT SECTION

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER'S NAME | SOC. SEC. NO.

RELATIONSHIP TO PATIENT | BIRTHDATE

NAME OF INSURANCE COMPANY

GROUP NO. | ADDRESS

SUBSCRIBER'S EMPLOYER | EMPLOYER PHONE NO.

SECONDARY INSURANCE

SUBSCRIBER'S NAME | SOC. SEC. NO.

RELATIONSHIP TO PATIENT | BIRTHDATE

NAME OF INSURANCE COMPANY

GROUP NO. | ADDRESS

SUBSCRIBER'S EMPLOYER | EMPLOYER PHONE NO.

HERITAGE DENTAL ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ , have received a copy of this office's Notice of Privacy Practices.

Please Print Name | **Signature** | **Date**

Heritage Dental Associates

Patient's Health History

Name _____ Birthdate _____

Has another dentist treated you in the past? Name _____ Phone _____

Medical doctor's name _____ Phone _____

Describe your general health _____

Have you had or do you have any serious illness? _____ Past surgery _____

Are you presently under a doctor's care _____ For what? _____

Chief dental concern? _____

Are you presently taking or have you taken any medications or drugs during the last 2 years, including birth control? Yes No, If Yes please list _____

_____

Are you presently taking herbal remedies? Yes No, if Yes please list _____

Have you had or do you now have any of the following? If Yes please specify

Anemia or Bleeding Disorder	☐Yes	☐No
Periodontal Disease	☐Yes	☐No
Diabetes	☐Yes	☐No
Thyroid Disease	☐Yes	☐No
Taken Cortizone / Steroid medications	☐Yes	☐No
Heart Murmur	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Angina Pectoris	☐Yes	☐No
Heart Disease / Heart Attack	☐Yes	☐No
Stroke	☐Yes	☐No
Pace Maker	☐Yes	☐No
Fainting or Dizzy Spells	☐Yes	☐No

Do you smoke or use smokeless tobacco	☐Yes	☐No
Epilepsy or Seizures	☐Yes	☐No
Asthma, Tuberculosis, Breathing Problems	☐Yes	☐No
Drug Addictions	☐Yes	☐No
Cancer	☐Yes	☐No
Hepatitis	☐Yes	☐No
HIV (AIDS) Positive	☐Yes	☐No
Artificial Joints	☐Yes	☐No
Taken Phen-Fen	☐Yes	☐No
Are you pregnant	☐Yes	☐No
Osteoporosis	☐Yes	☐No
Have you taken or are you taking: Fosamax, Actonel, Boniva, Aredia, Bonefos, Digronel, or Zometa	☐Yes	☐No
Do you have any allergies or adverse reactions to medications or drugs?	☐Yes	☐No

If Yes, please list: .....

.....

Do you have any diseases, conditions or problems not listed here? _____

Do you know of any other information that might affect your dental treatment? _____

Health Questionnaire Acknowledgment and Consent to Proceed: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Nield / Dr. Wilding 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 pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical appointment.

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.

I understand that as part of the dental treatment, including preventative procedures such as cleaning and basic dentistry, as well as 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 inadvertentlly 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 prevention of osteoporosis may result in complications of non-healing of jawbones following oral surgery.

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 preventative 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.

Signed _____ Date _____ Relationship to patient _____

OFFICE USE ONLY

_____ RMH _____ Date _____

_____ RMH _____ Date _____

_____ RMH _____ Date _____

_____ RMH _____ Date _____

Our Financial Policy

Thank you for choosing us as your dental care provider. As part of our service, we try to contain the ever-rising cost of dental care. 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 your treatment.

Patient/Insurance Information

We ask that a Patient Information and Health History Form be completed or updated before seeing the dentist to ensure proper treatment and billing.

I grant permission to you or your assignee to telephone me at home or at my workplace or any other telephone number listed to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

~Insured Patients:

Patients who carry dental insurance must understand that all services furnished are the responsibility of the patient. **Payment for your estimated portion of services is due at the time of each visit** which could include co-payments, deductible, percentage or non-covered benefits depending on your insurance plan requirements. As a courtesy to our patients, we prepare and process all insurance forms 3 (three) times. Having insurance does not release the patient from responsibility for services and the patient will be billed for those services until insurance is resolved. If a claim has not been paid within 60 (sixty) days, or the insurance has been billed 3 (three) times and remains unpaid, we ask that you pay the balance using one of the following methods of payment below. A rebilling charge of 1.5% per month will be assessed on any unpaid balance over 60 (sixty) days. Fee estimates are based on our experience with the insurance company and are not a guarantee of the insurance coverage.

~Non-Insured Patients:

Our financial policy is designed to give you a number of payment options to choose from in order to make your dental care payment as easy as possible. For your convenience, you may choose any of the following methods of payment:

- Cash
- Personal Check
- MasterCard, Visa, Discover or American Express
- Debit Card
- Pre-approved extended payment plans as well as short-term plans available with no interest through CareCredit and CitiHealth.

Minor Patients

The adult accompanying a minor and the parent (or guardian) are responsible for full payment. Parents must be present for all dental care authorization to minors.

Broken & Missed Appointments

Please help us serve you better by keeping scheduled appointments. Kindly notify us at least 24 hours in advance if you must cancel or reschedule an appointment. There is a ~~$50.00~~ $75.00 charge for all appointments that are broken or missed without a 24-hour cancellation notice.

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 hereby authorize the office of Heritage Dental Associates to use the following signature for proof of signature on insurance claim forms for assignment of insurance payments and release of information. **I agree to pay Heritage Dental Associates for professional services rendered to me at the time of service** or according to a payment policy pre-arranged by the office. I agree to pay within 30 (thirty) days of billing, if credit is extended. 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.

I agree to abide by the conditions outlined herein.

Signature of Responsible Party	Print Name	Date

Heritage Dental Associates

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT OT US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, out legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare 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 an authorization, you may 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you. As described in the patient rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose your health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim 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 health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: we may use or disclose your health information to you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: you have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies on a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.10 for each page, $15/00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. if you request this accounting more than once in a 12-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 or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make you request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will by handled under the alternative means or location you request.

Amendment: You have the right to request that we amend you health information (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: of you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your 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 also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your 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.

Contact Officer: Heather
Telephone: (801) 525-1415 Fax: (801) 525-0583
Email:_____
Address: 1747 S. Heritage Lane Suite A-1
Syracuse, Utah 84075