Alpine Meadows Family Dental

Today's Date: _____
Whom may we thank for referring you to us: _____

Patient Information:
Patient's Name:_____Date of Birth: _____Sex: ☐M ☐ F
Patient SS#: _____ Home Phone:_____ Work Phone: _____
Home Address: _____ City:_____ State: _____ Zip Code: _____
Driver's License #: _____ State:_____ Exp. Date:_____
Please send text message reminders to Phone #:_____ Email:_____
_____ **(Please initial). I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my phone number changes.**
Reason for Today's Visit:_____
Date of last dental exam:_____ Name of previous treating dentist: _____
Nearest relative not living with you: _____ Phone: _____
Patient's Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single

Responsible Party Information:
Responsible Party Name: _____ Date of Birth: _____ SS #:_____
Home Address: _____ City:_____ State: _____ Zip Code: _____
Mobile #:_____ Employer:_____ Work Phone: _____
Please Provide the Patient or Responsible Party's Spousal Information:
Spouse's Name: _____ Date of Birth: _____ SS #:_____
Mobile #:_____ Employer: _____ Work Phone: _____

Primary Dental Insurance Information:
Dental Insurance Company:_____ Phone #:_____
Billing Address:_____City:_____State:_____Zip Code: _____
Employer:_____Member ID #:_____Group #:_____
Policy Holder Information:
Name of Policyholder:_____Birthdate:_____Relationship to Patient: _____
Policyholder Address:_____City:_____ State:_____ Zip Code:_____

Secondary Dental Insurance Information:
Dental Insurance Company:_____ Phone #:_____
Billing Address:_____City:_____State:_____Zip Code: _____
Employer:_____Member ID #:_____Group #:_____
Policy Holder Information:
Name of Policyholder:_____Birthdate:_____Relationship to Patient: _____
Policyholder Address:_____City:_____ State:_____ Zip Code:_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I am responsible for updating this information if and when there are changes and will notify you of any changes in my status or in the above information. This information will be kept confidential.

Responsible Party Signature: _____ **Date:** _____

ALPINE MEADOWS FAMILY DENTAL - Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If Yes
Have you ever been hospitalized or had a major operation?	Yes	No	If Yes
Have you ever had a serious head or neck injury?	Yes	No	If Yes
Are you taking any medications, pills or drugs?	Yes	No	If Yes
Do you have, or have you taken, Phen-Fen or Redux?	Yes	No	If Yes
Have you ever taken Fosamax,Boniva, Actonel, or any other medications containing bisphosphonates?	Yes	No	If Yes
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	If Yes
Do you use controlled substances?	Yes	No	If Yes

WOMEN: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

ALLERGIES: Are you Allergic to any of the following?

☐ Aspirin ☐ Penicilin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Local Anesthetics ☐ Other: If Yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Shingles	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tumors or Growths	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Ulcers	Yes	No
Congential Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above ? Yes No If Yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: Date: Please Print Patient Name:

Alpine Meadows Family Dental

CONSENT TO PROCEED

I authorize Dr. Daniel R. Baird D.D.S. 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 cleaning 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 be 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, or 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 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 Name(s): _____

Signature of Patient or Guardian:_____ Date: _____

Witness: _____ Date: _____

Alpine Meadows Family Dental
1020 South 1100 West, Ste. A, Lehi, UT 84043
Phone: (801) 492-9207 Fax: (801) 492-3622
FrontDesk@AlpineMeadowsFamilyDental.com

CONSENT FOR PHOTO/IMAGE USE

I authorize the office of Daniel R. Baird, DDS to use the following images to be placed in a book of case samples, for website postings, marketing or advertising purposes:

Please check each approved:

☐ Before and after pictures of my teeth

☐ Before and after pictures of my full face

☐ No Cavity Club Photo! (Picture will be posted on our Facebook page)
Please provide your FB name so we may tag you:_____

☐ *I decline the use of my images*

By signing this authorization I waive any claims of breach of privacy pertaining to the release of any photographic or digital images as checked above. I acknowledge that I have received a copy of the privacy policies of this office.

_____
Patient Name(s)

_____ _____
Signature of Patient or Guardian Date

Alpine Meadows Family Dental

1020 South 1100 West, Ste. A, Lehi, UT 84043
Phone: (801) 492-9207 Fax: (801) 492-3622
FrontDesk@AlpineMeadowsFamilyDental.com

NOTICE OF PRIVACY PRACTICES
Effective date of notice: August 26, 2005
Dr. Daniel R. Baird, DDS
Contact HIPAA Compliance Officer: Elaine Partridge (801) 492-9207

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

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up appointments for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety; uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;

_____*Initials*

- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call, text, email or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, text, email or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail, text, (or email) you an appointment reminder on a postcard, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or email shown at the beginning of this notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or email shown at the beginning of this notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing.

_____*Initials*

- If you would like a list, send a written request to the office contact person at the address, fax or email shown at the beginning of this notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter if you have already received one electronically or in paper form. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or email shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

Patient Name(s):_____

Signature of Patient or Guardian:_____Date:_____

Alpine Meadows Family Dental

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

PAYMENT IS DUE AT TIME OF SERVICE: As a condition of your treatment by this office, financial arrangements must be made in advance as full payment is due at the time of service. 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 by cash or credit card at the time services are rendered.

MISSED/BROKEN APPOINTMENTS: Once an appointment has been made, that time is reserved specifically for you. Our office requires at least ***24 hours notice*** to reschedule any appointment. A fee of ***$30 per hour*** will be charged to the guarantor's account when the appointment is missed without sufficient notice or is broken the same day. I agree to pay the assessed fee along with all other charges to my account. I grant my permission to you or your assignee to contact me at home, on my mobile phone, 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 Alpine Meadows Family Dental to share further matters pertaining to **appointment information and account information** with following individuals:

Name: _____ Birthdate: _____ Name: _____ Birthdate: _____
Name: _____ Birthdate: _____ Name: _____ Birthdate: _____

BILLING PROCEDURES AND INTEREST: A service charge of $7 per month will be assessed on all accounts exceeding thirty (30) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for any dental care can only be extended for a period of 45 days from the date of the patient examination. There will also be a $40.00 fee for each returned check. In consideration for the professional services 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 his licensed employee or assignee at the time the services are rendered. I also agree to pay all other charges assessed to my account. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency. 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.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. 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. We do our best to estimate what your insurance will cover for services rendered. **However, we simply never know what insurance will pay until payment is received in our office.** Any additional amounts owed will be billed to the responsible party of the patient as necessary. Insurance may deny or delay processing of claims because they need more information from the policy holder. It is the policy holder's responsibility to provide information to their insurer, not the responsibility of this office. 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.

DIVORCE DECREES - Please understand that our office is not a party to your divorce decree. The responsible party is accountable for the minor's bill at time of service. We will be happy to print a receipt for a child's work so that you may submit it to another party for your reimbursement. Please be aware that the person listed on the minor patient's paperwork will be the person who receives the statements, bills and collection notices as necessary.

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

I have read the entire Financial Policy and understand it. I agree to be bound by all of these terms. By signing this document I allow Alpine Meadows Family Dental to use my signature to file insurance on my behalf. I hereby agree to abide by the conditions outlined herein.

Patient Name(s): _____ **Date:** _____

Signature of Patient or Guardian: _____

SUBMIT