SILVER SUMMIT DENTAL

Last Name_____ First Name_____ MI____ Preferred_____

Female/Male Single/Married/Minor DOB_____
SS#_____

Address_____CITY_____Zip_____

Email_____ Best phone# to reach you_____

Would you like to be included in our MONTHLY INFORMATIVE DENTAL NEWSLETTER

Yes ☐ **No** ☐

Personal Interest / Hobby _____ (optional)

How did you hear about us?_____

Person to contact in case of an emergency_____ phone#_____

****Cancelations less than 48 business hours in advance, excluding "life" events, will be assessed a $50.00 per clinical hour** We value your time, please value ours. Thank you**

Insurance Information

Primary

Insurance Provider_____

Policy Holder_____

DOB_____

Policy Holder's Employer_____

Group #_____Subscriber #_____

Relationship to Patient_____

Secondary

Insurance Provider_____

Policy Holder_____

DOB_____

Policy Holder's Employer_____

Group #_____Subscriber #_____

Relationship to Patient_____

Would you like to discuss ways to improve the appearance of your smile? Yes◯ No◯

Date of last dental care_____ What would you like us to do today?_____

Are you in dental discomfort?_____

Are you allergic to any of the following? ◯Aspirin ◯Penicillin ◯Codeine ◯Local Anesthetics ◯Latex

◯Sulfa drugs ◯Metal ◯Other _____

Although we primarily treat the area in and around your month, 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

Check if you have problems with any of the following

◯Y◯N Bad breath ◯Y◯N Food collection between teeth ◯Y◯N Periodontal treatment

◯Y◯N Bleeding gums ◯Y◯N Grinding or clenching teeth ◯Y◯N Sensitivity when biting

◯Y◯N Sensitivity to hot ◯Y◯N Clicking or popping jaw ◯Y◯N Sores or growth in mouth

◯Y◯N Sensitivity to cold ◯Y◯N Loose teeth or broken fillings ◯Y◯N Sensitivity to sweets

How often do you brush your teeth?_____ Floss?_____

Are you under a physician's care now? Yes Please explain_____

Current Medications_____

Do you have any heart or blood problems, including a heart murmur? ◯Y◯N

Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? ◯Y◯N

Do you have high blood pressure? ◯Y◯N

Do you bleed or bruise easily? ◯Y◯N

Have you ever been diagnosed as being HIV positive or having AIDS? ◯Y◯N

Have you ever had hepatitis A,B,C or liver disease? ◯Y◯N

Are you subject to fainting? ◯Y◯N

Have you ever been told you snore? ◯Y◯N

Have you ever had rheumatic fever _____; asthma_____; any blood disorder_____;

diabetes_____; rheumatism____; arthritis_____; tuberculosis_____; latex allergy_____;

heart attack_____; kidney disease_____; immune system disorders_____;

Do you take or have you taken Phen-fen or Redux? ◯Y◯N

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ◯Y◯N

Do you use tobacco? ◯Y◯N Do you use controlled substances ◯Y◯N

Women:

Are you pregnant or trying to get pregnant? ◯Y◯ Taking oral contraceptives? ◯Y◯

Nursing? ◯Y◯N

Signature: _____ Date_____

SILVER SUMMIT DENTAL

Office Policies

Appointments

For your convenience, we reserve a doctor for your specific appointment needs; we do not double book appointments. This allows us to make your dental experience a positive one. At each appointment, we have one Dental Assistant per patient. Your Dental Assistant is there to make your dental visit as positive an experience as possible, please let your Dental Assistant know if there is anything we can do to improve your experience. Because we reserve a Dental Assistant and Doctor for your specific appointment, we do charge a $50.00/hour cancellation fee for same day cancellations and or missed/no show appointments. If an emergency arises please contact the office as soon as possible to allow us time to open the time reserved for your appointment for another guest.

Emergency Care

If you or your family member have an accident or experience a flare-up of your condition when our office is closed, please call our emergency line 801-871-8106. Care received during non-office hours is subject to an additional charge. Please have your pharmacy information ready when contacting the emergency line, in case a prescription is issued.

Payments and Finance Options

We encourage you to ask questions and to be involved in your treatment decisions. This includes understanding your treatment plan as well as our financial policy. We accept cash, checks, and debit/credit cards for payment from **Established** patients. We are a proud contracted provider of **Care Credit**. Please as our office manager for more details. Patient Co-Payments are due at the time of service. A **5%** discount will be applied to those who prepay prior to your appointment. Please ask the front office for more details. **5% does not apply to Care Credit payments.

Insurance Billing

If you are insured, as a courtesy we will directly bill your company. If your insurance company has not paid us within 30 days from the date we sent the claim, we will then grant you 30 days to contact your company and demand payment. If no payment is received by the end of this 60-day period, you will be responsible to pay the full amount due and seek reimbursement directly from your insurance company. **All insurance estimated portions on your treatment plan are simply an estimate.** IF your insurance pay MORE than expected, the amount will be applied to your account to be used as your discretion. IF your insurance pays LESS than expected, you will be asked to cover this cost. All estimated patient copayments are due prior to services being rendered.

Financial Responsibility

I agree that the responsibility for payment of all services in this office, for my dependent(s) or myself is mine. I further understand that a $20.00 monthly finance charge will be added to any balance over 60 days. Any account over 90 days will be referred to a collection agency. In the event of a default, I authorized the release of financially identifiable information concerning my account, including charges billed, payments made, and finance charges assessed, etc. to the collection agency or collection attorney should collection procedures as described become necessary. I promise to pay any legal interest on the indebtedness, together with collection fees in the amount of 40% of the principal balance due, reasonable attorney's fees and court costs. As may be required to effect collection of this note.

I UNDERSTAND AND AGREE TO ABIDE BY THE POLICIES OF THIS OFFICE

Printed Patient Name_____ Patient (or Guardian)Signature_____

If patient is a minor please print Guardian Name_____

I authorize Silver Summit Dental and or such associates and 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 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 and TMJ disorder. Gums and surrounding tissue may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissue 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 Name:_____

Signature:_____ Date_____:
(Patient, legal guardian or authorized agent of patient) Witness: Date: (Rev. 7/08)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____