Coral Canyon Dental

PATIENT INFORMATION SHEET

Date: _____ Referred By: _____

Patient's Name: _____ SSN:_____ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Sex: M F Marital Status: M S W D

Employer: _____ Phone: _____ Occupation: _____

Student? Full Time Part Time

Spouse: _____ SSN:_____ Birthday:_____

Employer: _____ Phone: _____ Occupation: _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PERSON RESPONSIBE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ SSN:_____

Employer: _____ Number of Year Employed: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Union Local No.: _____ Work Phone: _____ Dental Insurance: _____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW

PRIMARY INSURANCE (Use your Identification Card)

Insured's Name: _____ SSN:_____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other: _____ ← Please Select One Option

Employer: _____ Phone: _____ Union Local No.: _____

Insurance Company: _____ Group #: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

SECONDARY INSURANCE (Use your Identification Card)

Insured's Name: _____ SSN:_____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other: _____ ← Please Select One Option

Employer: _____ Phone: _____ Union Local No.: _____

Insurance Company: _____ Group #: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Coral Canyon Dental

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Physicians Name: _____ Phone: _____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

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? If Yes, Specify condition(s) treated: _____	YES NO
3.	Do you take any medications including birth control pills? Please specify name and purpose of medications: _____ _____ _____	YES NO
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_____; diabetes_____; rheumatism_____; arthritis_____; tuberculosis_____; venereal disease_____; heart attack_____; kidney disease_____; immune system disorders_____; heart disease or endocarditis_____; other disease_____; Specify_____	YES NO
12.	Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetaminophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other_____; Specify_____	YES NO
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? <u>If Yes,</u> 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 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? <u>If yes,</u> have you seen you physician or cardiologist for a cardiac evaluation?	YES NO YES NO
25.	Have you ever used or are you now using tobacco or alcohol?	YES NO
26.	Have you ever taken Fosmax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?	YES NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FORGOING 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 RESPONSIBILTY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Coral Canyon Dental

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. 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 in cash at the time services are rendered.

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 wil l 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.

A monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the dat e of the patient examination.

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 licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. 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.

I grant my permission to you or your assignee to telephone me at home 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.

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

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.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____

Signature of Patient, Parent or Guardian Date

Relationship to Patient: _____

*The interest rate charged may be at the discretion of your office or accountant.

Coral Canyon Dental

CONSENT TO PROCEED

I authorize Dr. _____ 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 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 sw allowed. 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 standard dental 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: _____

Coral Canyon Dental

PRIVACY NOTICE ACKNOWEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officers is located in your copy of the Privacy Notice that is available on the website and in our office.

I, _____ **have received a copy of this office's Notice of Privacy Practices.**
(please print your name)

Signature: _____ Date: _____

IF PATIENT IS UNABLE TO ACKNOWLEDGE RECEIPT, STAFF MEMBER PROVIDING NOTICE TO COMPLETE THIS SECTION

The Privacy Notice was provided to:

Patient Name: _____ On this Date: _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following

reasons:_____

_____

_____

_____

_____

Staff Signature: _____ Date: _____

Coral Canyon Dental

2303 North Coral Canyon Blvd #202
Washington UT, 84780
435-652-4284

Dental Record Release Form

Patient Name To Transfer:_____

Date of Birth:_____ Phone Number:_____

Other Family Members to Transfer:_____

Previous Dentist or Practice Name:_____

Address:_____

City/State/ Zip:_____

Phone Number:_____

Please forward any of the following information that you have: X-Rays, Probing Depth Chart, Charting, and Photographs to Dr. Robert Gibson.

I hereby give you permission to releases any and all of my Dental Records to Dr. Robert Gibson

_____ _____

patient Signature (Parent if a minor) Date

*If records are digital, Please email to:

coralcanyondental@hotmail.com

Or mail to:

Coral Canyon Dental
2303 North Coral Canyon Blvd #202
Washington UT, 84780

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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.

According to HIPAA regulations you have the right to restrict the uses or disclosures of your information made for purposes of treatment, payment, and/or healthcare operations.

- Treatment is the provision, coordination or management of dental care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergencies.
- Payment includes the activities necessary to obtain reimbursement for the provision of dental care. For example, we may need to give your health plan information about treatment you received at our practice so your dental health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.
- Health care operations include the activities necessary for our practice to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at:

Coral Canyon Dental

2303 North Coral Canyon Blvd #202

Washington UT, 84780

435-652-4284

If your concern is not resolved, you may also submit a written complaint to the US Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

This practice is determined to protect the privacy of your medical information. As we provide service to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, obtain payment, and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to provide you with this notice
2. Update our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained
3. We reserve the right to make an important change in our privacy practices and change this Notice to that effect. You may contact us to request a new copy of our Notice and we will make the new Notice available upon request.

The following is a description of the different circumstances that may require our practice to use or disclose your medical information:

1. Share medical data with another provider who is responsible for your care (physicians, audiologists, dentists, nurses, any other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), make referrals and/or placing lab/prescription orders.
2. Share your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits. You may restrict certain disclosures to a health plan if the service received is paid for out-of-pocket.
3. Provide treatment communications concerning treatment alternatives or other health related products or services, unless we or a business associate receive financial remuneration in exchange for the communication in which case we must receive your written authorization unless the communication is made face-to-face or involves gifts of nominal value.
4. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.
5. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities.
6. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury, or disability.
7. Share medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.
8. Medical information may be disclosed when necessary to comply with Workers' Compensation.
9. Medical information may be disclosed in response to a court and/or administrative order in a lawsuit or similar proceeding.
10. In order to contact you for fundraising activities supported by our practice. You have the option to opt out of receiving these communications by sending a written request to the privacy officer.
11. For marketing purposes for which our practice or our business associates may receive remuneration, for a disclosure that constitutes a sale of protected health information, and in all other situations not described in this policy your written authorization will be obtained before our practice will use or disclose your health information to third parties outside our practice. You have the right to revoke such authorization by providing our practice with a written request to revoke the specific authorization.
12. If a use of disclosure is required by law, the disclosure will be made in compliance with the law and will be limited to such requirements. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow the more stringent requirements.

1. To business associates to perform functions on our practice's behalf, if the business associate has signed an agreement to protect the confidentiality of the information.
2. Share information about your condition(s), location and/or death to family member(s), or your personal representative(s). Prior permission by you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your healthcare.

You have individual rights as part of the Notice of Privacy Practices. As a patient of **Coral Canyon Dental**, you have the right to:

1. Request our practice to restrict uses and disclosures of your health information. However, we are not required to agree to the requested restriction unless you are requesting a restriction on the use and disclosure of your protected health information to a health plan for payment or healthcare operations and such information pertains to a healthcare item or service which you paid for in full and out of pocket. These requests should be made in writing to the address given in this Privacy Notice. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure, or both, and (c) to whom you want the limits to apply.
2. Be notified upon a breach of any of your unsecured protected health information.
3. Request that we communicate with you regarding your confidential medical information by different means or to different locations. This request must be made in writing to our practice.
4. Request photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the receptionist.
5. Request a change to your health information if you think it is incomplete or inaccurate. However, if the dentist, dental healthcare professional or office personnel believe the patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to **Coral Canyon Dental**.
6. Receive a list of all the times your medical information has been shared by our office or our business associates for six years prior to the request date, other than treatment, payment, healthcare operations and/or other specified exception.
7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to **Coral Canyon Dental**.

This Notice shall be effective as of ***August 1, 2013.***