CONFIDENTIAL PATIENT INFORMATION

Cedar Hills Family Dentistry LLC
4565 West Cedar Hills Drive
Cedar Hills, Utah 84062
801-756-9154

Name:_________________________________ SS:_______________________
Address:____
City:________________________________State:_______Zip:_______________
Phone #:(H)_________________(W)______________(CELL)________________
DOB:_____________________Email:_____________________________________
Marital Status:_______________ Spouse Name:__________________________
Occupation:____________________Referred By:__________________________

PERSON RESPONSIBLE FOR ACCOUNT

Name:________________________________SS#:_____________________________
Address:____
City:____________________________________State:______Zip:______________
Telephone:(H)_________________(W)________________(C)_________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co:____
Insurance Co. Address:____
Employee:____________________________Relationship:____________________
SS#________________________Policy#:_____________________________________
Employer:____
Secondary Insurance Co:____
Insurance Co. Address:____
Employee:_____________________________Relationship:___________________
SS#:__________________________Employer:_______________________________
Policy #:____

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: **Date:**

CONFIDENTIAL PATIENT INFORMATION-II

Patient Name: ______________________ Today's Date: ______________
Address: ______________________ City: ____________ Zip: ________
Home Phone: ____________ Cell: ____________ Work: ____________

HEALTH INFORMATION

Physician Name: ______________________________
Physician Phone #: ______________________________

Yes	No	
___	___	1. Have you been hospitalized within the past 2 years? For what? ______________
___	___	2. Are you currently being treated by a physician? For what? ______________
___	___	3. Are you currently taking any medications or prescriptions? What? ______________
___	___	4. Have you ever received counseling for excessive use of drugs or alcohol? ______________
___	___	5. Do you have any allergies to medication? What? ______________
___	___	6. Are you allergic to any metals? What? ______________
___	___	7. Have you ever had a skin rash or any other reaction to metal jewelry? To what? ______________
___	___	8. Do you bleed excessively upon injury?
___	___	9. Are you pregnant?
___	___	10. Have you ever been involved with dental/ medical legal activity?
___	___	11. Do you smoke?
___	___	12. Are you taking Fosomax? Or Medication for low Calcium? ______________
___	___	13. Have you ever had joint replacement surgery? If yes, Date? ____________ Joint Replaced? ______________

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE

A. Aids
B. Arthritis
C. Asthma
D. Cancer
E. Diabetes
F. Epilepsy
G. Glaucoma
H. Heart Murmur
I. Heart Problem, Explain: ______________________________
J. Hepatitis
K. High Blood Pressure
L. Jaundice
M. Kidney Problems
N. Low Blood Pressure
O. Rheumatic Fever
P. Nervous breakdown or Psychiatric Therapy
Q. Sexually Transmitted Diseases
R. Stroke
S. Tuberculosis
T. Other: ______________________

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: ______________________________
Address: ______________________________
Home Phone #: ______________ Cell Phone #: ______________

CONSENT TO PROCEED

I authorize Dr. Isaacson 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.

I understand that as part of 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. 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 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 may result in complications of non-healing of the 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 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:__________

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 preformed 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. The 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, the dental office can not 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 18% per month* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding 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 6 months from the date of the patient examination.

In consideration for the professional services rendered to be rendered for 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 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 my 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 manes 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 the forms 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

____

Relation to Patient

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

CONSENT FOR PHOTO/IMAGE USE

I, the undersigned, hereby authorize the office of ______________________ to use the following images to be placed in a book of case samples, or for marketing or advertising purposes:

______ Before and after pictures of my teeth

______ Before and after pictures of my full face

______ Before and after pictures of the teeth and/or full face of my minor child

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.

_________________________________ ______________________
Signature of Patient or Parent Date

_________________________________ ______________________
Witness Signature (member of office staff) Date

(Rev. 11/07)

HIPAA NOTICE OF PRIVACY PRACTICES

Cedar Hills Family Dentistry
4565 West Cedar Hills Drive – Cedar Hills, Utah 84062
Wm. Edward Isaacson DMD PC
Brian E. Isaacson DMD
(801) 756-9154

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 pamphlet, please ask to speak with out HIPAA Compliance Officer in person or by phone at our main number.

Signature below in acknowledgment that you have received this Notice of our Privacy Practices:

Patient Name:____

Signature:_______________________________ Date:________________

Relation to patient if minor:____________________________________

HIPPA NOTICE OF PRIVACY PRACTICES

Cedar Hills Family Dentistry
4565 West Cedar Hills Drive • Cedar Hills, UT 84062
(801) 756-9154

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 you 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 you health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health care 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, or mail a reminder of your next recall visit.
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 you rights with respect to you 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 you care of 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 have the right to receive an accounting of certain disclosures we have made, if any, of your protected 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 you privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of you complaint. **We will not retaliate against you for filing a complaint.**

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