Flynn Dentistry Kaysville

Date: _____

PATIENT INFORMATION (CONFIDENTIAL)

Patient's Name: _____ , __ _____ ____ Preferred Name: _____ Birthdate: _____
Last First Initial

Circle all that apply: MALE FEMALE MINOR SINGLE MARRIED DIVORCED SEPARATED WIDOWED

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

SOCIAL SECURITY #: _____ **EMAIL ADDRESS**: _____

Home phone #: (___)_____ Cell: (___)_____ Work: (___)_____ Best #(circle): Home Cell Work

Employer (or school if student): _____ Spouse (or Parent's names): _____

Spouse's Phone # (if applicable): _____

RESPONSIBLE PARTY

Person responsible for this account: _____ Relationship to patient: _____

Address/Phone (if different than above): _____ (___)_____

Driver's License #: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Work Phone#: (___)_____

INSURANCE INFORMATION

Name of Insured (Policy holder): _____ Relationship to patient: _____

Birthdate: _____ **SS#**: _____ Insurance Company: _____

Policy/ID#: _____ **Group#** (if applicable): _____

Do you have any additional dental insurance? (Circle) YES NO If yes, complete the following:

Name of Insured (Policy holder): _____ Relationship to patient: _____

Birthdate: _____ **SS#**: _____ Insurance Company: _____

Policy/ID#: _____ **Group#** (if applicable): _____

How did you hear about Flynn Dentistry Kaysville?: (Circle) ***Advertisement*** ***Phone Book*** ***Insurance List*** ***Location***

Referral (list below)

Whom may we thank for referring you to our practice? _____ Relationship: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE #: _____

DrFlynnDMD@Yahoo.com
801-497-0619 (Office) 801-497-0316 (Fax)

FLYNN DENTISTRY
KAYSVILLE
COSMETIC & FAMILY DENTISTRY
497-0619

Patient's Name: _____ , _____ _____
Last First Initial

MEDICAL HISTORY

The following information is necessary to safely receive dental treatment and will be held completely confidential. Since a change in medical condition or medication can affect dental treatment, I agree to notify the office of any future changes.

YES NO Are you taking any medications or substances? (Please list): _____
_____

YES NO **Allergies** to medications? (ie. Penicillin): _____ Other **Allergies** (ie. Metals):?_____

Please **CIRCLE** if you HAVE or HAVE HAD any of the following conditions and provide relevant details in the space below.

Heart Disease	**Heart Murmur**	**Pacemaker**	**High Blood Pressure**	**Bleeding disorder**	**Stroke**	**Artificial Joints**	**Serious illness (list below)**
Asthma	**Diabetes**	**Osteoporosis**	**Arthritis**	**Thyroid Problems**	**Seizures/Epilepsy**	**Hepatits**	**Major Surgery (list below)**
Stomach Problems	**Liver Problems**	**Kidney Problems**	**Tobacco use**	**Alcohol use**	**History of Drug/ Medication abuse**	**HIV/AIDS**	**Cancer or tumor**
Currently Pregnant	**Psychiatric Treatment**	**Depression**	**Anxiety**	**Severe Dental Anxiety**	**Eating Disorder**	**Frequent Cold Sores**	**Radiation treatment**

Details and history of circled conditions: _____

If you have any condition, disease or problem not listed above please indicate here: _____

YES NO N/A Are all of the above indicated conditions being treated and well controlled?: If no, explain:_____

YES NO I have read the above conditions and circled or otherwise listed all conditions that I have or have had in the past.

Approximately how long has it been since your last dental cleaning? _____

YES NO Are you interested in professionally whitening your teeth? **YES NO** Do you frequently clench or grind your teeth?

What is your main dental concern, if any? _____

CONSENT TO PROCEED

I hereby authorize Dr. Flynn and/or such associates or assistants as he may designate to perform procedures as may be deemed necessary or advisable to diagnosis, maintain or treat my dental health or the dental health of any other individual for which I have responsibility, including administration of any analgesic, sedative (including nitrous oxide), therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I also request and authorize him/her to do whatever he/she deems advisable if any unforeseen condition arises in the course of operations and/or procedures calling, in their judgment, for procedures in addition to or different from those contemplated. I will also follow any and all instructions as explained and directed to me and permit to prescribed diagnostic procedures.

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 on rare occasions needles can break and may require surgical retrieval.

I understand that as part of dental treatment (including preventive cleanings) teeth, jaw muscles, gums and surrounding tissues may become sensitive or uncomfortable both during and after completion of treatment. Dental materials and medications may also trigger allergic or sensitivity reactions. I also understand that holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. 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 receiving dental treatment there is an inherent risk of possible aspiration (inhale into the respiratory system) or swallowing loose materials in my mouth including, but not limited to, tooth fragments, filling materials, crowns, small dental instruments,etc. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require retrieval.

I understand the need to disclose any prescription drugs use, both previous and current. I understand that bisphosphonate medications for the prevention of osteoporosis, such as intravenous: **Aredia** (pamidronate), **Zometa** (zoledronate) or oral: **Fosamax** (alendronate), **Bonia**, (ibandronate) or **Actonel** (risedronate) 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 attest to the accuracy, truthfulness and completeness of the medical history information on this page. I also hereby attest that I have read the above disclosed 'Consent to Proceed' statement and assume any and all possible risks associated with obtaining dental treatment.

Patient's (or Guardian's) Signature: **X** _____ Date_____

Witness's Signature: _____ Date_____

Patient's Name: _____ , _____ _____
Last First Initial

HIPAA

I understand that, under The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that my medical records can and may be disclosed to others for each of the following purposes: 1. Treatment: providing, coordinating, or managing health care and related services by one or more health care providers. 2. Seeking financial reimbursement: obtaining payment for services, confirming coverage, billing or collection activities, and utilization review. 3. Health Care Operations including the business aspect of running a medical practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

A copy of Flynn Dentistry Kaysville's 'Notice of Office Privacy Practices' which contains a more complete description of the uses and disclosures of my health information is mounted on the waiting room wall. I acknowledge, that I have been given opportunity to read and obtain a copy of this document. I understand that this organization has the right to change it's Notice of Office Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice of Office Privacy Practices. I also understand that I may request in writing that Flynn Dentistry Kaysville restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand Flynn Dentistry Kaysville is not required to agree to my requested restrictions, but if they do agree then they are bound to bide by such restrictions.

RELEASE

I authorize release of any information concerning my (or my child's) health care, advice, x-rays, documentation, health history and treatment provided for the purpose of evaluating and administering claims for insurance benefits or seeking the advice and or further treatment by another dental professional. I also, hereby authorize payment of insurance benefits to be paid directly to the dentist or dental group, otherwise payable to me.

FINANCIAL POLICY (TRUTH IN LENDING)

As a condition of your treatment by this office, all dental services performed without previously made financial arrangements, must be paid for in full at the time service. I also understand that any fee estimate previously provided for anticipated dental care is subject to change without notice as our dental fee schedule (as well as insurance fee schedules) are occasionally adjusted for inflation.

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 rendered. Our office will help prepare an estimate, based on information provided to us by your insurance companies as to your anticipated co-pays and financial responsibility, however, I understand that this is just an estimate and in no way limits my financial responsibility. As a courtesy to our patients, our office will also assist in billing and collecting payments from your insurance companies. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the full actual bill for services. I understand I am financially responsible for payments in full of my accounts. By signing this statement, I revoke any possible previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

We hold the right to activate a service charge of 1.5 % per month (18% per annum) on the unpaid balance on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of provided services to Dr. Flynn or his assignee at the time services are rendered, or within ten (10) days of billing if credit shall be extended. I further agree that the reasonable value of services provided shall be billed unless objected by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed by me. Although we extend every possible avenue to make payments, unfortunately there are those who fail to pay their responsibilities, therefore we also hold the right to impose a finance charge based on the remaining balance due on any account deemed uncollectible prior to sending it to collections. The percentage of this finance charge may be assessed up to Utah's current maximum allowed limit, but will not exceed 40% of remaining balance. I understand this finance charge is assessed to pay for the collection process and it's subsequent costs and fees.

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 or care are null and void.

I hereby attest that I have read the above disclosed 'HIPAA' , 'Release' and 'Financial Policy (truth in lending)' statements and willingly agree and consent to be bound to and abide by the conditions outlined hereon.

Patient's (or Guardian's) Signature: **X**_____ Date_____

Witness's Signature: _____ Date_____