PATIENT INFORMATION

Patient's Name ____ Birthdate _____________ Age ___________
First MI Last

Check appropriate boxes: M ( ) F ( ); Single ( ) Divorced ( ) Widowed ( ) Married ( )
Address ____ City/State _______________________ Zip __________
Social Security Number _______-______-_______ Home Phone No. (___)______-_________
Occupation/Employer _________________________________ Cell Phone No. (___)______-_________
Work Address ____ City ________________ Zip ___________
Drivers License Number / State _________________________ Email ______________________________
In Case of emergency please contact: ______________________________ Phone No. ___________________
How did you hear about us? _____________________________________

RESPONSIBLE PARTY INFORMATION

Name ____ Relationship to patient _______________________
Address ______________________________________ City/State __________________ Zip _________________
Social Security Number ______-_____-______ Home Phone No. (___)______-_________
Occupation/Employer ______________________________ Work Phone No. (___)______-_________
Work Address ____ City _______________ Zip _________________
Drivers License Number / State _________________________________ Birthdate _________________________

INSURANCE INFORMATION

Primary Insurance Company ___________________________Id# __________________Grp#_____________
Name of Policy Holder _______________________________________ Birthdate __________________________
Social Security Number _______-______-________ Insurance Company Phone No. __________________________
Insurance Company Address ___________________________ City/State ____________________ Zip____________

Secondary Insurance Company __________________________________ Group/Policy No. __________________
Name of Policy Holder _______________________________________ Birthdate __________________________
Social Security Number _______-______-________ Insurance Company Phone No. __________________________
Insurance Company Address ___________________________ City/State ____________________ Zip____________

I hereby attest that the above information is true and correct to the best of my knowledge. In the event that this information changes I will inform Dr. Cold's office of the changes as soon as possible.

Signature: ____ Date: ________________________
(Patient, Legal guardian, or Authorized agent of Patient)

WARM FAMILY DENTISTRY, P.C.

4546 S Atherton Dr. #201
Salt Lake City, UT 84123
(801) 965-9898
Fax (801) 965-6194

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT AND CONSENT TO PROCEED:

I authorize Dr. Cold and/or such associates or assistants as 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: x-rays, laboratory procedures, 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 untoward reactions 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. 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 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 jawbones following oral surgery or tooth extractions.

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 do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative 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.

Signature ____ Date ____________________
(Patient, legal guardian or authorized agent of patient)

Witness ____ Date ____________________

WARM FAMILY DENTISTRY, P.C.

Patient Medical & Dental History

Patient Name: ____ Date of Birth: _______________________
Physician's Name: ____________________________________ Physician's Phone: __________________

Please answer the following questions completely (circle YES or NO)

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?..................... YES NO
3. Do you take any medications, including birth control pills?.. YES NO

Please specify name and purpose of medication (s) ____

____

____

4. Do you have or have you ever had any heart or blood problems?.. YES NO
5. Do you have a heart murmur?.. YES NO
6. Have you had a joint replacement?.. YES NO
7. Do you have Osteoporosis?.. YES NO
8. Have you ever, even once, taken Fosamax, Actonel, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? ……………...YES NO
9. Do you require antibiotic pre-medication for a heart condition, artificial valve, or artificial joint? YES NO
10. Do you have or have you ever had high blood pressure?.. YES NO
11. Do you bleed or bruise easily?.. YES NO
12. Have you ever been diagnosed with as being HIV positive or having AIDS?...................... YES NO
13. Have you ever had hepatitis or liver disease?.. YES NO
14. Have you had: rheumatic fever ____, asthma____, any blood disorder____, diabetes____, heart attack____, Kidney disease____, immune system disorders____, or any other disease, ____ If so, please specify ____
15. Have you ever had an unusual reaction or are you allergic to any of the following medications: Penicillin____, Aspirin____, Acetaminophen____, Ibuprofen____, Codeine____, Barbiturates ____, Sulfa drugs____, Latex____, Other: ____
16. Are you subject to fainting?.. YES NO
17. Have you ever had any severe reaction to dental treatment or local anesthetic?................ YES NO
18. Are you allergic to local anesthetic?.. YES NO
19. Do you have any other allergies?.. YES NO
    Please describe? ____
20. Have you undergone psychiatric treatment?.. YES NO
21. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? YES NO
22. Are you currently using recreational drugs?.. YES NO
23. How long ago did you last see a dentist: ________________________________
24. Are you now experiencing any dental pain?.. YES NO
25. When was your last dental check-up and cleaning? ________________________
26. Who was your previous dentist? ______________________________________
27. Do you think your teeth are affecting your general health in any way?.............................. YES NO
28. Do you have or have you ever had bleeding or sensitive gums?....................................... YES NO
29. Have you ever used the diet drug Fen-phen?.. YES NO
30. Women: Are you pregnant?.. YES NO
31. Do you smoke or use tobacco?.. YES NO

I hereby certify that the answers to the health questions are accurate and correct to the best of my knowledge and that I have fully disclosed all drugs that are being taken or "at-risk" drugs that I may have taken in the past such as Phen-fen. Since a change of medical condition or medications can affect dental treatment I understand the importance of and agree to notify the dentist of any subsequent changes

Signature: ____ Date: ______________________
(Patient, legal guardian or authorized agent of patient)

APPOINTMENT POLICY

We respect and value our patients and their time and we ask for the same respect in return. Therefore we have implemented an appointment policy which is outlined as follows:

- A **48 hour** notice is required for a cancellation of any appointment.
- There will be fees for broken appointments without a **48 hour** notice. The first broken appointment is $25, then, $45 thereafter for each broken appointment. These fees must be received before any future appointments can be considered.
- If a patient cancels or no-shows without **48 hour** notice to make rescheduling arrangements for the third time in a row, Warm Family Dentistry may not reserve any future appointments for this patient and the patient will be rejected by the practice.

We have implemented this policy for the purpose of being able to meet the needs and expectations of our patients in the time that has been reserved for that patient. When we have a cancellation that is less than the **48 hour** policy, we are not meeting the needs and expectations of our other patients who would have been able to use the time that has now been depleted.

I **UNDERSTAND** this policy and agree to give a **48 hour** notice if I need to cancel an appointment. I understand that the time set aside for my treatment is important and valuable to the Doctor, his staff, and myself.

Signature: ____ Date: __________________________
(Patient, legal representative or authorized personnel)

WARM FAMILY DENTISTRY, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, ____ have received a copy of this office's Notice of Privacy Practices.

____
Please print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgment

Other (Please Specify)

____

WARM FAMILY DENTISTRY, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required, by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 4-01-2003 and will remain if effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USES AND DISCLOSE OF HEALTH INFORMATION ABOUT YOU
We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance, conducting training programs accreditation, certification, licensing or credentialing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care or your location, your general condition, or death. If you are present then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Social Reviews. We may acknowledge your disclosure of attendance, treatment, experience, payment history, etc., through public online media, for example, if you leave a review that discloses you attended our office for treatment we may respond with "thank you for you review" or "our policies are…."

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other that photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice> We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. The fee for medical records is $1.00 per printed or electronic page and $1.00 per printed or electronic x-ray duplication. Additional fees apply for postage and handling.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we ay have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, please let us know. You also may submit a written complaint tot eh U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Office Manager, Warm Family Dentistry
Phone: 801-965-9898 Fax: 801-965-6194
E-mail: receptionist@warmfamilydentistry.com
Address: 4546 S. Atherton Dr. #201
Salt Lake City, UT 84123

Updated 04/18/2016