Abundant
DENTAL CARE

Today's Date:

PATIENT REGISTRATION

Confidential Personal Information

Name | ☐ M ☐ F Sex | / / DOB | Age

Street Address | City | State/Zip

☐ Single ☐ Married ☐ Separated ☐ Widowed Marital Status | - - Social Security Number

( ) - Cell Phone | ( ) - Home Phone | Email

Employer | ( ) - Work Phone | ☐ Yes ☐ No Are you a full-time student?

/ / Mother's DOB (if patient is a minor) | / / Father's DOB (if patient is a minor) | Name of Spouse (or parent if patient is a minor)

( ) - Spouse's Cell Phone | ( ) - Spouse's Work Phone | Spouse's Email | Spouse's Employer

Responsible Party

☐ Self ☐ Other Person responsible for account | Name (if other than self) | Relationship (if other than self) | Driver's License Number

( ) - Cell Phone | ( ) - Work Phone | Email

Emergency Contact

Emergency Contact Name | ( ) - Cell Phone | Email

Other

How were you first introduced to Abundant Dental Care? ☐ Mailer ☐ Web Search ☐ Social Media ☐ Drove By

☐ Referral from family/friend ☐ Insurance Carrier ☐ Other ________

Dental Insurance

Primary Insurance	**Secondary Insurance**
Insured's Name & DOB:	Insured's Name & DOB:
Social Security #:	Social Security #:
Insurance Carrier:	Insurance Carrier:
Insurance Carrier's Phone#:	Insurance Carrier's Phone#:
Insured's Employer:	Insured's Employer:
Group #: ID#:	Group #: ID#:

Check all that apply: ☐ I do not have dental insurance ☐ I am interested in receiving information on an In-House Discount Plan

Abundant
DENTAL CARE

Patient's Name:

MEDICAL HISTORY FORM

Please check any of the following problems/conditions that apply to you:

- ☐ AIDS
- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Pregnant (currently)
- ☐ Radiation (head/neck)
- ☐ Respiratory problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sinus problems
- ☐ Sleep Apnea
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other ____________

Are you allergic or have you reacted adversely to any of the following medications?

- ☐ Aspirin
- ☐ Darvon
- ☐ Nitrous Oxide
- ☐ Percodan
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Tetracycline
- ☐ Codeine
- ☐ Erythromycin
- ☐ Valium
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ____________

Have you ever taken any of the following medications?

- ☐ Actonel
- ☐ Aredia
- ☐ Fosamax
- ☐ Reclast
- ☐ Zometa
- ☐ Boniva
- ☐ Herbal Supplements
- ☐ Other ____________

Are you under a physician's care? If yes, for what reason?

____

____

____

Please list current medications:

____

____

____

Name of Physician: ____________

Phone: ____________

Do you currently smoke or use tobacco? Y or N

If so, for how long? ____________

Sleep Questionnaire

0 - *No chance of dozing*
1 - *Slight chance of dozing*
2 - *Moderate chance of dozing*
3 - *High chance of dozing*

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place (e.g., a theater or a meeting)
_____ As a passenger in a car for an hour without a break
_____ Lying down to rest in the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after a lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic

Total ________

Consent: *I, the undersigned, hereby authorize Abundant Dental Care and its doctors and/or employees to take X-rays, study models, photographs and/or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. I also authorize any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.*

Patient's Printed Name

Signature *(Patient, legal guardian or authorized agent of patient)* — Date

Provider's Signature — Date

Patient's Name:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES *and* AUTHORIZATION TO RELEASE

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge I have received a copy of Abundant Dental Care's HIPAA Notice of Privacy Practices:
NOTE: YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, the undersigned, have received a copy of Abundant Dental Care's Notice of Privacy Practices.

Patient's Printed Name ______________________ Date ______________________

Signature ______________________

Authorization to Release Information (Optional)

I, the undersigned, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself:

Printed Name ______________________ Phone Number ______________________

Printed Name ______________________ Phone Number ______________________

Dental Office Use Only

(To be completed if patient chooses not to sign above)

We attempted to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ___ An emergency prevented us from obtaining acknowledgement
- ___ A communication barrier prevented us from obtaining acknowledgement
- ___ The individual declined to sign
- ___ Other: ______________________

Signature of Witness ______________________ Date ______________________

Abundant
DENTAL CARE

Patient's Name:

FINANCIAL POLICY *and* AGREEMENT

Policy

Thank you for choosing Abundant Dental Care as your dental health care provider. We are committed to providing you with the highest quality dental care. The following is a statement of our financial policy which we require you to read, agree to and sign prior to any treatment. We thank you for the opportunity to serve you and welcome any question you may have concerning our financial policies.

- Payment for services is considered a part of your treatment and is due prior to treatment
- For co-pays of $250 or more, payment is due to secure the appointment time
- Forms of payment include: cash, personal check, MasterCard, Visa, Discover and American Express
- We offer third party financing options; approval is granted solely by the crediting company
- We offer a very affordable In-house Discount Plan, details of which are available upon request
- Returned checks are subject to additional fees, up to $50
- A $50 fee may be applied for appointments cancelled/broken with less than 24-hour notice
- Should it become necessary to enlist a collection service and/or legal assistance in collecting monies due to Abundant Dental Care, you will be responsible for any collection and/or legal charges

Dental Insurance Overview

As a courtesy, we will assist with the processing of all insurance claims. We will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. We will strive to provide an accurate estimate; however, your insurance company and your plan benefits are ultimately determined by the carrier.

All charges incurred are your responsibility, regardless of insurance coverage. As your dental care provider, our relationship is with you—our patient—not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract.

Our practice is committed to providing the best treatment for all patients and we will charge what is usual and customary for the local market. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to obtain an expected payment date. If payment is not received within 60 days of the filing date, and/or your claim is denied, you will be responsible for paying the amount in full immediately. Any amount not paid will be subject to 18% interest per annum. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

To pursue treatment, your signature is required on this form as well as any other forms required by your insurance company.

Agreement:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided by this office for myself or my dependents is my own, and/or attorney fees will be added to any overdue balance that requires collection initiatives.

I understand that in the absence of prompt payment, my personal and financial records concerning these professional services will be released to Abundant Dental Care's legal representative(s) for collection. The legal representative will act as the providers "business associate" in compliance with the federal Health Insurance Portability and Accountability Act.

By signing below, I am authorizing Abundant Dental Care to call me at any number provided. I also agree to any fees or charges that you may incur or for incoming or outgoing calls, to or from any such number, without reimbursement.

Patient's Printed Name

Date

Signature

Abundant
DENTAL CARE

Patient's Name:

AUTHORIZED REPRESENTATIVE FORM

Acknowledgement of Receipt of Notice of Privacy Practices

______________________________, a patient of Abundant Dental Care, has verbally granted permission for another individual to act as an Authorized Representative on his/her behalf during dental visits and/or treatment. As such, the patient states he/she understands he/she is granting permission for said Representative to sign on his/her behalf, any required documents or forms; including but not limited to consent forms, statements of understanding, informational sheets, etc.

The patient further understands assigning an Authorized Representative does not release him/her from any consents, permissions or understandings outlined in any all paperwork read, reviewed or signed by the Authorized Representative.

____

Authorized Representative Name

____

Phone Number

____

Relationship to Patient

Dental Office Use Only

______________________________*, an employee of Abundant Dental Care, spoke to the patient mentioned above and was informed of his/her desire to assign an Authorized Representative during his/her dental visit and/or treatment. The Authorized Representative indicated above is the name of the person said patient indicated as his/her choice of representation.*

______________________________ ______________________________

Signature of Witness Date

Abundant
DENTAL CARE

Patient's Name:

ABUNDANT DENTAL CARE, PC

CONSENT TO PROCEED

I authorize Abundant Dental Care, PC, and its associates or assistants 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 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. 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's Printed Name

Signature *(Patient, legal guardian or authorized agent of patient)*

Date

Witness

Date

Abundant
DENTAL CARE

HIPAA NOTICE OF PRIVACY PRACTICES

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.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Abundant Dental Care ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, please can contact the Practice Manager at: 793 E Winchester St, Murray, UT 84107 or 801.441.3143.

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your 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.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on December 15, 2015.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. **Treatment.** We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. **Payment.** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. **Health Care Operations.** We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. **Appointment Reminders.** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. **Treatment Alternatives and Health-Related Benefits and Services.** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. **Disclosure to Family Members and Friends.** We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. **Disclosure to Business Associates.** We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. **Disclosures Required by Law.** We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. **Public Health Activities.** We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. **Victims of Abuse, Neglect or Domestic Violence.** We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. **Health Oversight Activities.** We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. **Lawsuits and Legal Actions.** We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. **Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. **Organ, Eye and Tissue Donation.** We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. **Research Purposes.** We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. **Serious Threat to Health or Safety.** We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. **Specialized Government Functions.** We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. **Workers' Compensation.** We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual’s rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is December 15, 2015.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.