REDWOOD DENTAL
HEALTH CENTER

David P. Blanco D.D.S.
Redwood Dental Health Center
4370 South Redwood Road
Salt Lake City, UT 84123
(801) 969-1802

Getting To Know You As Our Patient

Patient Last Name ______________________ First Name ______________________
Home Phone ________________ S.S.N. ______________ Birthdate ________________
E-mail ______________________________________ Cell Phone ________________
Home Address ____
City ____________________________ State ____________ Zip ________ Gender ❍M ❍F
Primary Insurance Company ____________________ Group ________ Subscriber __________
Secondary Insurance Company __________________ Group ________ Subscriber __________

Responsible Party

Name ________________________________ Relationship to Patient ________________
Home Phone ________________ S.S.N. ______________ Birthdate ________________
Home Address ____
City ____________________________ State ____________ Zip ________________
Marital Status ❍Single ❍Married ❍Divorced ❍Separated Drivers License and State ____________
Employer ____________________ Occupation ______________ Work Phone __________
Business Address ____
City ____________________________ State ____________ Zip ________________
Spouse's Name ________________ S.S.N. ______________ Birthdate ________________
Employer ____________________ Occupation ______________ Work Phone __________
Business Address ____
City ____________________________ State ____________ Zip ________________

How did you hear about our office?

Who selected this Office? *(check only one)*
❍Self ❍Spouse ❍Parent ❍Employer

Where did you find the phone number to this office? *(check only one)*
❍Referred by a friend ❍Yellow Pages ❍Relative ❍Insurance plan
❍Welcome Utah ❍Sign by building ❍TV/Radio ad ❍Newspaper ad
❍Direct mailing ❍Other ____

Consent

*I will answer all health questions correctly, to the best of my knowledge _______
Initial

I hereby authorize the performance of dental services on the above named patient, along with whatever procedures needed to carry out these dental services, as deemed necessary based upon the judgment of the doctor. I also authorize and request the administration of any anesthetics and x-rays as deemed necessary and advisable by the doctor.

Signature ____________________________ Date __________ Relationship to Patient ______________

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Patient's Dental History

Why have you come in to see us today? *(e.g.:pain,checkup,etc.)* ______
Previous Dentist ______ Last Visit ______ Date of last cleaning ______
Reasons for changing dentists ______
What problems have you had with past dental treatment? ______
Are you nervous about seeing a dentist? ❍Yes ❍No If yes, please tell us why ______
How often do you brush? ______ Do you floss? ❍Yes ❍No How Often? ______

Please answer Yes or No to the following questions.

Y	N	
❍	❍	I clench or grind my teeth during the day or while sleeping.
❍	❍	My gums bleed while brushing or flossing.
❍	❍	I like my smile.
❍	❍	I prefer tooth-colored fillings.
❍	❍	I avoid brushing part of my mouth due to pain.
❍	❍	I want my teeth whiter
❍	❍	My gums feel tender or swollen
❍	❍	I have problems eating
❍	❍	I have had orhodontics.
❍	❍	I have had a facial or jaw injury.
❍	❍	I want my teeth straight.

What are your dental priorities? ______
(e.g.: apprentice, dental health, financial considerations,etc.)

Patient's Medical History

I consider my health to be *(please check one)* ❍Excellent ❍Good ❍Fair ❍Poor
Do you or have you had any of the following? Please select Yes or No.

Y	N	
❍	❍	Heart Disease
❍	❍	Heart Murmur/Mitral Valve Prolapse
❍	❍	Stroke
❍	❍	Congenital Heart Lesions
❍	❍	Rheumatic Fever
❍	❍	Abnormal Blood Pressure
❍	❍	Anemia
❍	❍	Prolonged Bleeding Disorder
❍	❍	Tuberculosis or Lung Disease
❍	❍	Asthma
❍	❍	Hay Fever
❍	❍	Sinus Trouble
❍	❍	Epilepsy/Seizures
❍	❍	Ulcers
❍	❍	Liver Disease
❍	❍	Jaundice
❍	❍	Hepatitis Type ______
❍	❍	Diabetes
❍	❍	Excessive Urination and/or Thirst
❍	❍	Infectious Mononucleosis (Mono)
❍	❍	Herpes
❍	❍	Arthritis
❍	❍	Sexually Transmitted/Venereal Disease
❍	❍	Kidney Disease
❍	❍	Tumor or Malignancy
❍	❍	Cancer/Chemotherapy
❍	❍	Radiation Treatment
❍	❍	History of Drug Addiction
❍	❍	AIDS
❍	❍	Immune Suppressed Disorder
❍	❍	Hearing Loss
❍	❍	Fainting Spell
❍	❍	Glaucoma
❍	❍	History of Emotional or Nervous Disorders
❍	❍	(Women) Are you taking birth control medication?
❍	❍	(Women) Are you or could you be pregnant or nursing?
❍	❍	Implants/Artificial Joints ❑Hip ❑Knee ❑Other
❍	❍	I smoke or use tobacco. If yes, how much per day?______ How many years?______
❍	❍	I have consumed alcohol within the last 24 hours.
❍	❍	I usually take an antibiotic prior to dental treatment.
❍	❍	Have you ever taken Fen-Phen or Redux?
❍	❍	I have had a major surgery:

Year ______ Type of operation ______
Year ______ Type of operation ______

❍ ❍ Do you have any other medical problem or medical history NOT listed on this form? ______

Doctor's Notes Only:

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Patient's Medical History (continued)

Are you allergic to any of the following?
Please Select Y for yes or N for no

Y	N	
❍	❍	Aspirin
❍	❍	Ibuprofen
❍	❍	Sulfa Drugs/Sulfites/Sulfides
❍	❍	Penicillin
❍	❍	Codeine
❍	❍	Latex, Metals, Plastics
❍	❍	Local Anesthetics (Novocaine)
❍	❍	Other Medications - Which ones? ____________________

Please list all medications you are currently taking.

Medicine ____________________ Condition ____________________
Medicine ____________________ Condition ____________________
Medicine ____________________ Condition ____________________
Medicine ____________________ Condition ____________________
Physician's Name ____________________
Address ____________________
Phone ____________________ Fax ____________________

In the event of an emergency please contact

Name ____________________ Relation ____________________ Phone ____________________
Name ____________________ Relation ____________________ Phone ____________________

Initial medical/dental health reviewed by:

X____________________ ____________ X____________________ ____________
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X____________________ ____________ X____________________ ____________
Doctor's Signature Date Parent/Guardian's Signature Date

Terms and Conditions

Payment Policy: While this office will accept reimbursement from most of our patient's insurance plans towards the costs incurred for treatment in our office, the financial responsibility for treatment ultimately resides with the responsible party, signing this form. I understand that dental services provided to me and/or the patient listed above will be charged directly to me and that I am personally responsible for payment. If I carry dental insurance, I understand that this office will help prepare my insurance claim forms for the purpose of collection from my insurance company and will credit any insurance payments to my account. However, this dental office cannot and does not provide services on the assumption that charges will be paid by an insurance company.

I therefore understand and agree that as a condition of treatment, financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed, unless other arrangements have been made.

Assignment of Insurance: I hereby authorize the release of any information needed by my dentist and/or this office. Additionally, I authorize my insurance company to pay claims due under the benefits of my insurance policy directly to my dentist and/or this office.

Fees and Collection Policies: I understand that the fee estimate provided in the treatment plan for dental care is valid only 90 days from the date of the examination and presentation of the treatment plan. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number and/or other information I have provide to this office. I agree that in the event any legal proceedings are initiated either by me or this office with respect to amounts owed by me for services rendered, the prevailing party in such proceedings will be entitled to recover all costs incurred, including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed ____ Date ____________________

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

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NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION 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 the Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices described in this Notice while it is in effect.
We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. 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 by calling our office of simply downloading this form from our website.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations as indicated by the following examples.
Treatment: We may disclose or use 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 a payment for services we provided you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations; you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or discloses permitted by your authorization while it is in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: 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, of 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 to your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up the filled prescriptions, medical supplies, X-rays, or other similar forms of health information.
Marketing and Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information as required by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety, or the health or safety or others.
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 officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

OTHER PATIENT INFORMATION WE CONSIDER IMPORTANT:

We take out patients' satisfaction with our dental care and customer service very seriously.
Access to your medical information: You have the right to look at or get copies of your dental records and history. We ask that you request your medical records in writing and give us a reasonable time frame to respond. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies we will charge you 0.15 cents per page, $16.00 per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, such as electronic delivery, we will charge a cost-based fee for providing your health information in the format requested. Additionally, if you prefer, we will prepare a summary or an explanation of your health information, for a fee.
Disclosure of Release of Information: You have the right to receive a list of the occasions in which we or our business associates disclosed your health information for purposes other than or including treatment, payment, healthcare operations and/or other legally approved instances. 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 these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information and/or payment arrangements by alternative means or to alternative locations. We ask that you provide these instructions in writing, specifying the alternative means or location, and provide satisfactory explanation how payments will be made under the alternative means or location you request. We will do everything that we can to accommodate your request.
Amendment: You have the right to request that we amend your health information. We ask that you make this request in writing, explaining why the information should be amended. Please know that may not be able to honor your request under certain circumstances.
Questions and Complaints: If you have any questions or concerns about our privacy practices please contact us. If you are concerned that we may have violated your privacy rights or you disagree with a decision we have 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 alternative locations, please let us know and we will do everything we can to resolve your concerns.
Likewise, if you have a billing concern, please bring it up to our office manager immediately, so we can resolve your concern. If for any reason you have a concern regarding the dental care we have provided to you, please communicate your concern with us promptly. If we do not know you have a concern, we can't address it with you and resolve the situation.