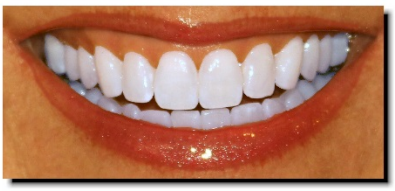
Intermountain Smiles



Benjamin Young, DDS

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801-352-8288
www.IntermountainSmiles.com

General, Cosmetic and Implant Dentistry

Please fill out these forms as completely as possible. If you have any questions or need assistance please ask a staff member. We will be happy to help you.

Patient's name _____ Preferred Name_____

Date of birth _____/_____/_____ Marital Status _____

Social Security # _____

Home address _____ City_____

State_____ Zip Code_____

Home phone _____ Cell phone _____

E-mail_____

☐ Check this box if you prefer ***not*** to receive appointment reminders by email or text.

How did you hear about our office?_____

Occupation _____ Work Phone _____

Employer _____

Emergency Contact _____ Relationship_____

Phone_____

RESPONSIBLE PARTY/INSURANCE INFORMATION

Name of Account Holder _____ SSN or ID#_____

Date of birth _____/_____/_____ Group or Policy #_____

Insurance Carrier _____

Employer _____

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Please be advised of the following financial, insurance, and privacy policies:

- ***If you have dental insurance:*** The responsible party is accountable for all dental bills in our office. Our staff will help with completion and submission of primary insurance forms as an accommodation and convenience to you. It is the patient's responsibility to know their insurance benefits, assure collection of insurance payments, and to negotiate with the insurance company over any disputed claims. Some insurance policies may allow, but do not cover certain procedures such as lab fees and/or diagnostic tests. Any co-payments are due at the time of the appointment unless other arrangements have been made. Some insurance policies allow for an alternate benefit on selected procedures. In the event of such, the patient is responsible for any difference in allowable co-pay. Many insurance carriers do not cover cosmetic procedures; if this is the case the patient is responsible for the full payment of these services. We may be able to assist you with any questions; please don't hesitate to ask. As a service to you, your insurance will be billed with your consent upon signing this form.

- ***Health Insurance Portability and Accountability Act of 1996:*** This office is in compliance with regards to the electronic submission of patient information to third party payers. All patient records are maintained on a secured database with access by employees of Intermountain Smiles only.

- ***If you do not have insurance:*** Payment in full is expected at time of service or advance financial arrangements must be arranged.

- ***Forms of payment:*** We accept payments in cash, check, money order, or most major credit cards. We can also assist you in applying for health care credit through a third party program (service charge(s) may apply).

- ***The responsible party agrees to:***
  1. Pay the doctor at the time service is rendered.
  2. Pay 2% per month (24% annually) on the unpaid balance with a minimum charge of $2.00 repeat billing fee per month on balances over 60 days.
  3. Cover the balance of this account within 60 days from the date of service in the event the insurance company does not pay the entire balance within that time.
  4. Returned check fee of $25.00, or the maximum allowable by law.
  5. Pay on past-due amounts, collection fees of up to 40% of the principal owing (U.C.A. sec. 12-1-11), court costs and attorney fees.
  6. Unpaid accounts may be subject to collection fees.
  7. Pay a fee for failing to keep a confirmed appointment or canceling with less than 24 hours notice.

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. In addition to receiving a written copy of this Notice, it may be viewed online at www.intermountainsmiles.com/privacy.htm

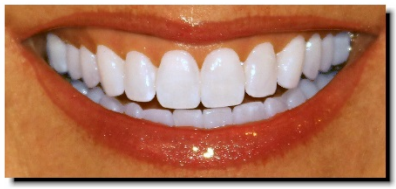
☐ **Check this box if you do not want us to discuss your treatment with *any* family members (Spouse, etc).**

I agree to the Financial Policy of this office and have read the privacy policy.

_____ _____

Signature *Date*

Intermountain Smiles



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PATIENT RIGHTS AND RESPONSIBILITIES INFORMATION SHEET

RIGHTS

1. The right to treatment with respect, consideration and dignity, provided in a safe environment, free from all forms of abuse or harassment. The patient may exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
2. The right to privacy concerning your dental care.
3. The right to confidential treatment of all communications and records pertaining to your care and your visit(s). The patient also has the right to access information contained in your dental record within a reasonable time frame (24 hours of request, excluding weekends and holidays).
4. The right to be fully informed regarding one's oral health condition.
5. The right to participate in the development and implementation of your plan of care and actively participate in decisions regarding your dental care. To the extent permitted by law, this includes the right to request and/or refuse treatment. Information from Dr. Young about your dental health, your course of treatment, (including unanticipated outcomes), and prospects for recovery in terms you can understand.
6. The right to receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each.
7. The right to examine and receive the fees for service, the explanation of your bill and the payment policy regardless of source of payment. Upon request and prior to the initiation of care, receive an estimate of charges, potential insurance payments and an estimate of co-payment, deductible, or other charges not paid by insurance.
8. The right to understand and sign an Informed Consent form before receiving care.
9. The right to appropriate assessment and management of pain.

RESPONSIBILITIES

1. The patient has the responsibility to provide complete and accurate information to the best of your ability concerning your health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
2. The patient and family are responsible for asking questions when they do not understand, what a staff member has told them about the patient's care or expectations of what they are to do.
3. The patient is responsible for following the treatment plan prescribed by Dr. Young.
4. The patient/guardian is responsible for a nominal fee for failure to keep a confirmed appointment or cancel within 24 hours of the scheduled appointment
5. The patient is responsible for knowing and providing your healthcare insurance information, and accepting personal financial responsibility for any charges not covered by your insurance, assuring the financial obligations of your care are fulfilled as promptly as possible.
6. The patient is responsible for the consequences if he/she refuses treatment or fails to follow Dr. Young's instructions.
7. The patient is responsible for being respectful of all the health care professionals and staff as well as other patients.
8. The patient is responsible for following office policies and procedures.
9. The patient is responsible for being respectful of office property and that of other persons in the facility.

I have read and fully understand the information in this form.

_____ _____

Patient/Guardian signature Date

MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Primary Care Physician's Name: _____

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

1. Are you now or have you been under a physician's care within the past year? . . . . . .YES NO
   If yes, specify condition being treated _____
2. Do you take any medications, including birth control pills or health supplements? . . . . . .YES NO
   Please specify name and purpose of medications: _____
   _____
   _____
3. Women: Are you pregnant? . . . . . .YES NO
4. Have you had a total joint replacement? . . . . . .YES NO
5. Do you have any heart problems? . . . . . .YES NO
6. Do you have high blood pressure? . . . . . YES NO
7. Do you require antibiotic pre-medication for a heart condition or artificial valve? . . . . . YES NO
8. Have you ever taken Fosamax, Boniva, or another drug for osteoporosis? . . . . . .YES NO
9. Have you ever had hepatitis or liver disease? . . . . . YES NO
10. Have you ever been diagnosed as being HIV positive or having AIDS? . . . . . YES NO
11. Have you ever had (check any that apply):
    asthma _____ any blood disorder _____ tuberculosis_____
    diabetes _____ arthritis _____ heart attack_____
    kidney disease___ immune system disorders_____other disease _____

12. Have you ever had an unusual reaction to, or are you allergic to any of the following drugs:
    Penicillin _____ Aspirin _____ Acetaminophen _____Sulfa Drugs_____
    Ibuprofen _____ Codeine _____ Other_____
13. Are you subject to fainting? . . . . . YES NO
14. Are you allergic to any local anesthetic? . . . . . YES NO
15. Do you use tobacco (smoke/smokeless)? . . . . . YES NO
16. Do you have any other allergies? If yes, please describe: _____
17. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? . . . . . .YES NO
18. Do you have bleeding or sensitive gums? . . . . . YES NO
19. If you are now in any dental pain, please explain: _____
    _____
20. When was your last dental visit? _____
21. Who was your previous dentist? _____
22. Are you interested in whitening your teeth in the near future? . . . . . .YES NO
23. Do you have any questions or concerns you would like to speak to Dr. Young about (crooked or chipped teeth, smile design, bad breath, frequent cold sores, teeth grinding, gaps between teeth, etc)? _____
    _____

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical and dental status. I authorize Dr. Benjamin Young and/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. 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 do voluntarily assume any and all possible risks, 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 any foregoing procedures will be explained to me if necessary and I will be given the opportunity to ask questions. I understand that any pictures/images taken may be used for educational and/or promotional use.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patent)