PATIENT INFORMATION DATE _____

NAME _____ □ Male □Female
Last First Middle Name

SOCIAL SECURITY # _____ □ Married

ADDRESS _____
Street Apt. # City State Zip

BIRTHDATE _____ TELEPHONE _____ _____ _____
Month Day Year Home Work Cell

EMAIL ADDRESS _____NAME OF EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE_____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: □ PATIENT □ GUARDIAN □ SPOUSE □FATHER □MOTHER

Has a family member ever been treated in our office? [Name of Parent or Spouse_____
Their Employer_____
Employer Phone & Address _____

INSURANCE INFORMATION

PRIMARY INSURED/If no insurance complete for responsible party	**SECONDARY INSURED**
_____ LAST FIRST M	_____ LAST FIRST M
_____ STREET CITY STATE ZIP	_____ STREET CITY STATE ZIP
_____ HOME WORK CELL	_____ HOME WORK CELL
_____ BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP	_____ BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP
_____ EMPLOYER DENTAL INS. CO.	_____ EMPLOYER DENTAL INS. CO.
_____ SS# SUBSCRIBER # PHONE #	_____ SS# SUBSCRIBER # PHONE #

EMERGENCY CONTACT (other than immediate family)

Name _____

City/State/Zip _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____
Responsible Party

_____
Date State Driver's License #

REFERRAL INFO: How did you learn about our office?

_____

METHOD OF PAYMENT

Card # _____ Exp Date _____
□ Payment in full at each appointment (□Visa □MC □ Other)
□ Payment in full at each appointment (cash or personal check)
□ Care Credit
□ I wish to receive information on Care Credit & may want to apply
□ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGES & FEES

I agree to pay interest at the rate of 18% annually (1.5% per month, or a minimum charge of $1.00 for a balance under $100) on any past due balances (30 days from the original due date).
If I pay by check and my check does not clear, I will pay a $20 returned check fee. If my account becomes delinquent and Dr Powell must take additional steps to collect my balance, I will pay court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance. If my account is assigned to a collections agency I will pay a collection fee.

PATIENT DATA SHEET

RATE YOUR SMILE

☹1 2 3 4 5 6 7 8 9 10☺

What do you like about your smile?

_____
_____

What if anything would you change about your smile?

_____
_____

Do your teeth feel comfortable to your tongue? YES/NO If no, where is it uncomfortable?

_____
_____

Are you pleased with the color of your teeth? YES/NO

Are you pleased with the shape of your teeth? YES/NO

Are your teeth sensitive to Hot or Cold? YES/NO

Are your teeth sensitive when you eat sweets? YES/NO

Are you comfortable with the smell and taste of your breath? YES/NO

Is there anything else we should know about your smile today?

_____
_____

David B. Powell D.D.S.

7478 S Campus View Dr., Ste 202
West Jordan, UT 84084
(801) 280-6911
www.jordanlandingsmiles.com

NAME_____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questionnaire are accurate and correct to the best of my knowledge. Since a change in medical condition or medications can affect dental treatment, I understand the importance of, and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. David B. Powell 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 arrangement 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, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and require surgical retrieval.

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 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.

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

Witness:_____**Date:**_____

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
***If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.**

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐	Sleep Apnea	☐	☐	Cochlear implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ **Date** _____ **BP** _____ **Pulse** _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ **and confirm that it adequately states past and present conditions.**

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____

Financial Arrangement Agreement

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to your dental care. We ask that you read and sign this statement prior to any treatment.

PAYMENT IS DUE FOR ALL SERVICES AT THE TIME OF TREATMENT

In our desire to be fair and impartial, we require this of all our patients.
We accept Cash, Check, Visa, MasterCard, Discover Card and American Express. For extensive treatment plans, we offer an extended payment plan on credit approval.

Regarding Insurance

We will gladly file all dental claims for given treatment but **we are not party to any insurance programs or contracts.** The balance is **YOUR** responsibility whether your insurance company pays for your treatment or not. If we are a preferred provider for your insurance, our contract requires that we collect your co-pay and deductable in full at the time of the treatment.
IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES IN YOUR INSURANCE COVERAGE. Failure to notify us of insurance changes will result in a fee of $10 to resubmit your claim to your current insurance.

Missed Appointment Fee

In order to be fair to all our patients who are seeking a convenient appointment time, we ask that you notify our office at least **2 of OUR business days** in advance if you can not keep your scheduled appointment. Our policy is to charge a **$35.00 fee** for a missed appointment or late cancellation.

Finance Charges & Collection Fees

I understand that any unpaid balance after 30 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. I understand that if I pay by check and my check does not clear, I will pay a $20 returned check fee. I understand that if my account becomes delinquent and Dr. Powell must take additional steps to collect my balance, I will pay fees incurred by Dr. Powell including collection agency fees and attorney's fees.

Permission to Contact Via Cellular Telephone

I authorize Dr Powell, or any other person or entity who provides goods or services in connection with this agreement, to contact me regarding servicing or collecting on my account, for all past and current transactions and balances. I specifically authorized you to contact me by telephone at any number, including cellular, mobile, or other wireless telephone numbers I have or may obtain. I also authorize you to contact me by text messages, or e-mails to any of my telephone numbers or e-mail accounts. I realize there may be a charge from my telephone carrier on any of these calls.

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time. Our office hours are ***Monday, Tuesday, and Thursday from 8am to 5pm and Fridays from 8am to 1pm****. If there is any emergency after hours please call our office at 801-280-6911 and press 3 to be directed to our emergency cell phone and someone will return your call as soon as possible.*

Signature_____ Date_____

David B. Powell D.D.S.

NOTICE OF PRIVACY PRACTICES
Of David B. Powell, DDS PC

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 7, 2003* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Sarah Woolley. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:
Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.
(a)Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure as made for purposes other than providing service, payment, and or business operations. To request this list of accounting disclosures you must submit your request in writing to our Privacy Office. List, if request, will be $__ for each page and the staff time charged will be $___ per hour including the time required to locate and copy of your health information. Please contact our Privacy Office for a fee and/or for an explanation of our fee structure.
(b)Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where "the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment): and the PHI pertains solely to a healthcare item or service for which our facility has been paid our of pocket in full.
Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.
Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.
Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.