
**Patient's Name** _____ **Date** _____

*Please complete the following patient registration and confidential health history*

## STEP 1: PATIENT INFORMATION

*Address* _____ *City* _____ *State* _____ *Zip Code* _____

*Home Phone#* _____ *Work#* _____ *Cell#* _____

*Email Address* _____

*Birthdate* _____ *Age** _____ *School* _____ *Grade* _____

*SS#* _____

*Single Married Divorced Widowed* *(*if appointment is for your child, please list school and grade)*

## STEP 2: INSURANCE INFORMATION

*Primary Carrier* _____ *Group #* _____

*Insurance Company* _____ *Phone#* _____

*Address* _____ *City* _____ *State* _____ *Zip Code* _____

*Employer* _____ *Phone#* _____

*Insured Employee Name and Birthdate* _____

## STEP 3: PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

*Name* _____

*Address* _____ *City* _____ *State* _____ *Zip Code* _____

*Home Phone#* _____ *Work#* _____ *Cell#* _____

*SS#* _____ *Driver's License#* _____

*Employer* _____

*Birthdate* _____

*Work Address* _____ *City* _____ *State* _____ *Zip Code* _____

*Spouse's Name* _____

*Employer* _____ *Work Phone#* _____

## STEP 4: GETTING TO KNOW YOU

*Referred to us by? or How did you hear about Alpine Dental?* _____

*Their name (we want to thank them)* _____

*Address* _____ *City* _____ *State* _____ *Zip Code* _____

*Is a member of your family a patient in our office? Their name:* _____

*Your hobbies and interests?* _____

continue

## STEP 5: EMERGENCY CONTACT INFORMATION

*Name of an individual you would like us to contact in an emergency:*

*Address* *City* *State* *Zip Code*

*Home Phone#* *Work#* *Cell#*

*Closest relative NOT living with you* *Relationship*

*Address* *City* *State* *Zip Code*

*Home Phone#* *Work#* *Cell#*

## STEP 6: PLEASE READ & SIGN

*Office policies and federal truth in-lending statement*

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at the time of service. There may be a fee assessed for missed appointments.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of a 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

*In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty days of billing if credit shall be extended; I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (up to 50% principle) that may be assessed by any collection agency retained to pursue this matter.*

*I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.*

*I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Benjamin Leaver and/or his associates dba Alpine Dental.*

*I certify that I have answered all questions on the form accurately and I hereby agree to abide by the conditions outlined therein.*

**Signature of Patient, Parent or Guardian** **Date** **Relationship to Patient**

**Patient's Name** _____ **Date** _____

## STEP 1: MEDICAL HISTORY FORM

*Please read and answer the following questions*

**Y N** 1. Are you having pain or discomfort at this time?

**Y N** 2. Do you feel nervous about having dental treatment?

**Y N** 3. Have you been hospitalized during the past two years?

**Y N** 4. Have you been under the care of a medical doctor during the past two years?

*Physician's Name* _____ *Type of Practice* _____

*Address* _____ *Phone#* _____

**Y N** 5. Have you taken any medication or drugs during the past two years?

*If yes, please list:* _____

**Y N** 6. Are you allergic or have you reacted adversely to any of the following medications? Please circle.

| | | | |
|---|---|---|---|
| *Aspirin* | *Nitrous Oxide* | *Valium* | *Local Anesthetic* |
| *Darvon* | *Erythromycin* | *Scopolamine* | *(Novocaine or Xylocaine)* |
| *Codeine* | *Tetracycline* | *Penicillin* | *Sleeping Pills* |
| *Demerol* | *Percodan* | *(Nembutal/Seconal)* | *Other* _____ |

**Y N** 7. Circle any of the following, which you have had or have at present:

| | | |
|---|---|---|
| *Heart Failure* | *Emphysema* | *A.I.D.S. or H.I.V.* |
| *Heart Disease or Attack* | *Cough* | *Hepatitis A (infectious)* |
| *Angina Pectoris* | *Tuberculosis (TB)* | *Hepatitis B (serum)* |
| *High Blood Pressure* | *Asthma* | *Hepatitis C* |
| *Heart Murmur* | *Hay Fever* | *Liver Disease* |
| *Rheumatic Fever* | *Sinus Trouble* | *Yellow Jaundice* |
| *Congenital Heart Lesions* | *Allergies or Hives* | *Blood Transfusion* |
| *Scarlet Fever* | *Diabetes* | *Hemophilia* |
| *Heart Pacemaker* | *Thyroid* | *Fever Blisters* |
| *Heart Surgery* | *X-ray or COBALT Treatment* | *Epilepsy or Seizures* |
| *Artificial Joints (Hip, Knee)* | *Chemotherapy (Cancer, Leukemia)* | *Fainting or Dizzy Spells* |
| *Anemia* | *Arthritis* | *Nervousness* |
| *Stroke* | *Rheumatism* | *Psychiatric Treatment* |
| *Kidney Trouble* | *Cortisone Medicine* | *Sickle Cell Disease* |
| *Ulcers* | *Glaucoma* | *Bruise Easily* |
| *Cosmetic Surgery* | *Pain in Jaw Joints* | *Other* _____ |
| *Drug Addiction* | *Cold Sores* | |

**Y N** 8. When you walk up stairs or take a walk, do you ever have to stop because of pain in the chest, shortness of breath, or because you are very tired?

**Y N** 9. Do your ankles swell during the day?

**Y N** 10. Do you use more than 2 pillows to sleep?

**Y N** 11. Are you on a special diet? If so, please explain. _____

**Y N** 12. Do you have any disease, condition, or problem not listed? _____

**Y N** 13. Have you visited a dentist in the past year? Date of last visit _____

*FOR WOMEN ONLY:*

**Y N** 14. Are you pregnant? Date due:

**Y N** 15. Are you taking birth control pills?

**Patient's Signature** _____ **Date** _____

continue

## STEP 2: REVIEW OF MEDICAL HISTORY

I have reviewed the foregoing Medical History (other side) and find it to be unchanged and accurate, except as noted.

| Signature of Patient, Parent or Guardian | Date | Update |
|---|---|---|
| Signature of Patient, Parent or Guardian | Date | Update |
| Signature of Patient, Parent or Guardian | Date | Update |

## STEP 3: PLEASE READ & SIGN

*Health questionnaire and acknowledgement with consent to proceed*

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. 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 changes at any subsequent appointment.

I authorize Dr. Benjamin Leaver 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 administration of any sedative (including nitrous oxide), analgesic, 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 permanent numbness, and muscle soreness.

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 as necesary and I have been given the opportunity to ask questions.

| Signature of Patient, Parent or Guardian | Date | Relationship to Patient |
|---|---|---|

{Alpine Dental}

# 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 this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this 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. 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.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**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 payment for services we provide to you.

**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.

**Your Authorization:** In addition to our use of your health information for treatment, payment or 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 an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a 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 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, 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 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.

**Required by Law:** We may use or disclose your health information when we are required to do so 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 abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of 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 official 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).

---

PATIENT 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 than 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. If you request copies, we will charge you $15.00 for each page, $_15.00__ per hour for 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, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

---

# Alpine Dental

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement**

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 acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

# Alpine Dental

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This practice may request to post pictures for the purpose of informing other patients of the positive outcome. The practice is not receiving any compensation from your or anyone else for this picture, and it will not be used outside of the office, nor will any private personal information accompany the picture. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice, at any time by contacting:

Contact Person: Stacy, Clinical Dental assistant

Telephone: (801) 451-7812 Fax: (801) 451-8962

Email: benleaverdmd.gmail.com

Address: 1466 North HWY 89 Farmington Utah 84025

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.