Riverside DENTAL CARE

# Dr. Ott • Dr. Stevens • Dr. Wade

368 East Riverside Drive, #2A • St. George, UT 84790
(435) 673-3363 • www.stgeorgesmiles.com

## PATIENT INFORMATION

First Name_____M.I._____Last Name_____Birthdate_____
(Please Check Your Answer) Sex: ☐ Male ☐ Female Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐
Mailing Address_____City_____State_____Zip_____
Physical Address_____City_____State_____Zip_____
Work Phone_____Home Phone_____Cell Phone_____
Employer_____
Drivers License Number_____City_____State_____Zip_____
Social Security Number_____Email Address_____
Names of family members who are patients here_____
Whom may we thank for referring you to our office_____
In case of emergency, who should be notified?
1) Name_____Phone_____ 2) Name_____Phone_____

## PERSON RESPONSIBLE FOR THIS ACCOUNT

(If patient is a minor child, please complete the next 2 sections for the child's parents)

Name_____Relationship to Patient_____Birth Date_____
Home Address (if different from above)_____
Employer_____Social Security Number_____Business Address_____
Payment Method_____ ☐ Cash ☐ Credit Card Number_____ _____/____
I_____ hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company(if offered at this office)
Home Phone_____Work Phone_____Cell Phone_____

## PATIENT'S SPOUSE OR OTHER PARENT

Name_____Relationship to Patient_____Birth Date_____
Home Address (if different from above)_____
Employer_____Social Security Number_____
Business Address_____
Home Phone_____Work Phone_____Cell Phone_____

## INSURANCE INFORMATION

Dental Insurance ____Yes____No Effective Date_____
Subscriber's Name_____
Subscriber's Birth Date_____
Subscriber's Employer_____
Insurance Company_____
Group No._____SSN/Contract No._____

Medical Insurance_____Yes_____No Effective Date_____
Subscriber's Name_____
Subscriber's Birth Date_____
Subscriber's Employer_____
Insrance Company_____
Group No._____SSN/Contract No._____

## SECONDARY INSURANCE INFORMATION

Dental Insurance ____Yes____No Effective Date_____
Subscriber's Name_____
Subscriber's Birth Date_____
Subscriber's Employer_____
Insurance Company_____
Group No._____SSN/Contract No._____

Medical Insurance ____Yes____No Effective Date_____
Subscriber's Name_____
Subscriber's Birth Date_____
Subscriber's Employer_____
Insurance Company_____
Group No._____SSN/Contract No._____

## MEDICAL HISTORY

Name of Your Primary Care Physician_____Phone_____
Date of last physical_____
Are you taking any MEDICATION now (PRESCRIPTION AND /OR OVER-THE-COUNTER)?_____Yes_____No
If yes please list_____
Are you pregnant? Yes☐No ☐ Do you take hormones? Yes☐ No ☐ Do you take birth control pills? Yes ☐ No ☐
Do you have a history of any of the following (please check all that apply)?

- ☐ ALCOHOLISM
- ☐ ANEMIA
- ☐ ANY BLEEDING PROBLEMS
- ☐ ANY CHRONIC INFLAMMATORY DISEASE I.E. LUPUS
- ☐ ANY JOINT REPLACEMENT
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BONE DISORDERS
- ☐ CANCER
- ☐ DIABETES
- ☐ DRUG ABUSE/TREATMENT
- ☐ EMOTIONAL PROBLEMS
- ☐ EMPHYSEMA
- ☐ FREQUENT HEADACHES
- ☐ GROWTH DISORDERS
- ☐ HEARING LOSS
- ☐ HEART ATTACK
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HERPES (FEVER BLISTERS)
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISORDERS
- ☐ LEUKEMIA
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MITRAL VALVE PROLAPSE
- ☐ NERVOUS/ANXIOUS
- ☐ OPEN HEART SURGERY
- ☐ PACE MAKER
- ☐ RECREATIONAL DRUG USE
- ☐ RHEUMATIC HEART DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SEIZURES
- ☐ SICKLE CELL ANEMIA
- ☐ SINUS DISEASE
- ☐ STOMACH OR INTESTINAL ILLNESS
- ☐ STROKE
- ☐ TESTED HIV POSITIVE
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE
- ☐ TOBACCO USE

Do you have a history of allergies to:
MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) ☐ Yes ☐No If yes, please list_____
LOCAL ANESTHESIA ☐ Yes ☐No If yes, _____
OTHER(foods, respiratory, fluoride, etc.) ☐ Yes ☐No If yes, _____
ADDITIONAL INFORMATION ABOUT YOUR HEALTH THAT WE SHOULD KNOW_____
_____
Have you ever had any unusual reactions to any drug or anesthetic? Yes No _____
Is there any other information about your health that we should know? Yes No _____

## DENTAL HISTORY

Name of your former dentist_____
Address_____Date of last appointment_____
Do you want full dental care?_____Yes_____No An estimate of treatment charges will be given.
Reason for first visit with us_____
Please add anything that you feel is important for the doctor to know_____
_____
_____

## PAYMENT OF PROFESSIONAL FEES

Payment at the time of services is expected. For your convenience, we accept VISA and MASTER CARD. Our office will be happy to submit claims to your insurance company. A service charge of 1.2 % per month will be added to all balances 60 days and older. The annual rate of the service charge is 18% I understand that Riverside Dental Care will make every effort to collect from my insurance company. I hereby authorize Riverside Dental Care to furnish information to insurance carriers concerning my treatment and I hearby assign to the dentist all payments for dental services rendered to me or my dependents. By signing this form, I acknowledge and understand that I am responsible for any amounts not covered by insurance for services rendered to me or my dependents. I also acknowledge and understand that if the account is turned over to an attorney or collection agency for collection, I hereby agree to pay forty percent (40%) attorney or collection agency fees on the unpaid balance.

Date_____Signature_____

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# Financial Options

**Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology.**

## DENTAL INSURANCE

We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and insurance company.

As a courtesy to you, we will file your insurance and accept assignment benefits if you signed the insurance authorization form. We ask that the uninsured portion be paid at the time of service. We accept all credit cards (Visa, MC, Discover and AMEX), for your estimated co-pay.

## NON-INSURED PATIENTS

For uninsured patients, all fees are due at time of treatment. You may use cash, check, debit, or credit card.

For those who need extended payment arrangements, we offer Care Credit, a finance plan that offers interest-free loans up to twelve months on approval of credit.

## PAYMENT COURTESY

For treatment plans greater than $500.00 if paid prior to the first appointment, you will receive a 5% payment courtesy.

## DENTAL LABORATORY

If your treatment requires the use of a dental lab, a minimum of 50% of your estimate is required on your first treatment appointment.

## RELATED INFORMATION

Returned checks may be subject to bank processing fees. If payments are extended beyond 30 days from the first billing, account holder will pay 1.5% per month on unpaid balances. Annual percentage Rate 18% minimum monthly charge $0.50. Late fee may also apply.

In an event that the account is not paid and we refer the account to a collection agency, you are responsible for and agree to pay all attorney fees, with or without suit, court costs and a collection fee of 40% which will be added to the outstanding balance of your account.

## RESERVED APPOINTMENTS

Your appointment time has been reserved exclusively for you. Any change in your appointment such as missed or short notice changes affects many patients. A 24 hour notice is required to avoid a $25.00 missed appointment charge.

**I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from services rendered.**

NAME:(please print)_____

SIGNATURE_____DATE_____

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Do you like the appearance of your teeth? ☐ Yes ☐ No
If not, Explain _____

Are your teeth in alignment(Straight)? ☐ Yes ☐ No
If not, Expain _____

Do you have spaces that you don't like? ☐ Yes ☐ No
If not, Expain _____

Do you like the color of your teeth? ☐ Yes ☐ No
If not, Expain _____

Do you like the shape of your teeth? ☐ Yes ☐ No
If not, Expain _____

Are you teeth; ☐ Chipped ☐ Protruding ☐ Hidden

Do you like the way teeth come together? ☐ Yes ☐ No
If not, Expain _____

Are there old fillings or dental work that you don't like the looks of?
If not, Expain _____

Are there old fillings or dental work that you don't like the looks of?
If not, Expain _____

What would you like to change most in the appearance of your teeth? _____

How would you like your teeth to look? _____


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368 E. Riverside Dr. Bldg. #2
St. George, UT 84790

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

•You may refuse to sign this acknowledgment•

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)

_____

_____

Our Doctors and staff understand that your dental and health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

How We Use Your Health Information

When you receive care from us, we may use your health information for treatment, billing for services, and conducting our normal business as a health care operation. Examples of how we use your information include:

- Treatment- We keep records of the care services we provide for you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with the specialist who will assist in your treatment. Some health records, including confidential communication, may have additional restrictions for use and disclosure under state and federal laws.
- Payment- We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to verify coverage with your insurance company for your care, to notify them of upcoming services that may need prior notice or approval, or to obtain payment for you.
- Health Care Options- We may use health information to improve the quality of your care, train staff and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our community. For example, we may use your health information to request prior authorization for a test or procedure, to call in prescriptions for you, etc.

Other Services We Provide

We may also use your health information to:

- Recommend treatment alternatives.
- Tell you about health services and products that may benefit you.
- Share information with family or friends involved in your care or payment for your care.
- Share information to third parties who assist us with treatment, payment, and health care operations. Our business associates must follow our privacy practices.
- Remind you of an appointment by telephone message or postcard reminder.

Sharing Your Health Information

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations are:

- For public health purposes as permitted by law, such as reporting injuries and communicable diseases and reporting reactions to drugs and problems with dental products.
- To protect victims of abuse, neglect, or domestic violence.
- For health oversight activities such as investigations, audits, and inspections.
- For lawsuits and similar proceedings.
- When otherwise required by law.
- When requested by law enforcement as required by law or court order.
- When requested by coroners, medical examiners, and funeral directors.
- For research approved by our review process under strict federal guidelines.
- To reduce or prevent a serious threat to public health and safety.
- For workers' compensation or other similar programs if you are injured at work.
- For specialized government functions such as intelligence and national security.

All other uses and disclosures are not described in this notice require your signed authorization. You may revoke your authorization at any time with a written statement.

Our Privacy Responsibilities

Riverside Dental Care is required by law to:

- Maintain the privacy of your health.
- Provide this notice that describes the way we use and share your health information.
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain.

Your Individual Rights

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial.*
- Request corrections or additions to your health information. *
- Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures required by law. Your request must state the period of time desired for the accounting, which must be within six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made within a 12 month period.*

Request marked by a star (*) must be made in writing. Contact the Privacy Officer for the appropriate form for your request.

Contact Us

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made concerning access to your health information, contact:

Rebecca Lucero
Privacy Officer

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St. George, UT 84790
(435) 673-3363

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.