***Welcome!!!*** Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we are happy to help.

Name _____ Email _____

Gender: M/F Status: Married/Single Spouse Name _____

Phone: Home _____ Cell _____ Birthday _____ SS# _____

Address _____ City _____ State _____ Zip Code _____

Insurance Comp _____ Pharmacy _____

Emergency Contact _____ Phone # _____

Please provide your insurance card for us to copy. Thank you!

Whom may we thank for referring you to our practice? _____

Person Responsible for Payment of this Account

Name _____ Relationship _____ Birthday _____

Address _____ City _____ State _____ Zip _____

Phone # _____ SSN _____

Employer _____ Employer Phone # _____

Insurance Information

Insured Name _____ SSN _____ Birthday _____

Relationship to patient Self _____ Spouse _____ Child _____ Other _____

Employer _____ Employer Phone # _____

Insurance Company _____ Ins. Phone # _____

Group # _____ ID# _____

Secondary Insurance

Insured Name _____ SSN _____ Birthday _____

Relationship to patient Self _____ Spouse _____ Child _____ Other _____

Employer _____ Employer Phone # _____

# LANCE D. BAILEY DDS

**5685 South 1475 East, STE 1A**
**South Ogden, UT 84403**
**801-475-8000**

## CONSENT TO PROCEED

I authorize Lance Bailey, DDS 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, therapeutic, 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, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment, items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require brochoscopy or other procedures to ensure safe removal.

I understand the need to disclose to Dr. Bailey any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non -healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all reasonable medical/dental risks including the risk of substantial and serious harm, if any, which may be associated with standard dental 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.

Patient Name: _____

Signature: _____ Date:_____

(Patient, Legal Guardian, or Authorized Agent of Patient)

Signature of witness:_____ Date:_____

Lance Bailey's office has taken measures to protect all of our patients' private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices. Your protected health information will be used by us or disclosed to others for the purpose of the treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records. See the receptionist to receive a copy. You may request a restriction on the use or disclosure of your protected health information. wE may or may not agree to restrict the use or disclosure of your protected health information. If we agree to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards. You may revoke this consent to the use and disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. PCHC reserves the right to modify the Privacy Practices outlined in the notice.
Please see the receptionist with any questions prior to signing this authorization form.

## Pick ONE please

I, _____, DOB _____ am authorizing the person/people listed below to obtain medical information about myself. I understand Lance Bailey's office is not responsible for the information provided as long as it is given to a person that I have listed below. Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

I have reviewed this consent form & give my permission to Lance Bailey's office to Use & Disclose my health information in accordance with the Federal Privacy Standards.
Patients Signature: _____ Date: _____
If guardian, relationship to patient: _____

I, _____, **do not** authorize to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.
Patient's Signature: _____ Date: _____
If guardian, relationship to patient: _____

I, _____, do authorize this emergency contact _____ to be called only in case of emergency. I understand none of my private information will be released.
Relationship:_____ Phone:_____

# PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other that office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access the PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I _____date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____ Relationship to Patient _____

# MEDICAL and DENTAL History

Name_____ Date of birth_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE

1. Do you consider yourself to be in good health? YES NO
2. Are you now or have you been under a physician's care within the past year? YES NO
   If YES, specify condition being treated _____
3. Do you have or have you ever had any heart or blood problems? YES NO
4. Have you ever been told that you have a heart murmur? YES NO
5. Do you have or have you ever had high blood pressure? YES NO
6. Do you bleed or bruise easily? YES NO
7. Are you subject to fainting? YES NO
8. Have you ever been diagnosed as being HIV positive or having AIDS? YES NO
9. Have you ever had hepatitis or liver disease? YES NO
10. Have you ever had: asthma_____; any blood disorder_____; kidney disease_____; diabetes_____;joint pain/arthritis_____; tuberculosis_____; pneumonia_____; heart attack_____; heart disease or endocarditis_____; immune system disorders_____; rheumatic fever_____; other significant disease_____: If so, please specify:
    _____
11. Do you take any medications (including birth control pills)? YES NO
    Please Specify name and purpose of medications:_____
12. Have you ever had an unusual reaction or are you allergic to any of the following drugs: YES NO
    Penicillin_____; Aspirin_____; Acetaminophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other_____
13. Do you require antibiotic pre-medication for a heart condition, artificial valve or joint, etc.? YES NO
14. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? YES NO
15. Have you ever used or are you now using tobacco or alcohol? YES NO
16. Is there any **family** history of substance abuse or misuse? YES NO
17. Is there any **personal** history substance abuse or misuse? YES NO
18. Have you ever received counseling for use of alcohol and/or prescription drugs? YES NO
19. Do you take any sedative medication including herbal supplements? YES NO
20. Do you have any other allergies? If YES, please describe:_____ YES NO
21. Have you ever had a nervous breakdown or undergone psychiatric treatment? YES NO
22. Women: Are you pregnant? Due date_____ YES NO
23. Are you now is pain? YES NO
24. If you are a new patient, how long ago did you last see a dentist? _____
25. If you are a new patient, who was your previous dentist? _____
26. Do you think your teeth are affecting your general health in any way? YES NO
27. Have you ever had any severe reaction to dental treatment or local anesthetics? YES NO
28. Are you allergic to any local anesthetics? YES NO
29. Do you have or have you ever had bleeding or sensitive gums? YES NO
    If YES, have you seen your physician or cardiologist for a cardiac evaluation? YES NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE IN MY MEDICAL CONDTION OR MEDICATIONS TAKEN CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY DR. BAILEY OF ANY CHANGES AT SUBSEQUENT APPOINTMENTS.

Signature:_____ Date:_____

(Patient, Legal Guardian or Authorized Agent of Patient)

# Dr. Lance D. Bailey Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is necessary in order for us to provide treatment.

## Patients with Dental Insurance

As a courtesy to our patients, we prepare and process all insurance forms. However, having insurance does not release the patient from financial responsibility.

Our expectations of you as the owner of the policy are as follows:

1. Estimated patient portions must be paid at the time of service. This may include co-payments, deductibles, co-insurance and/or non-covered procedures.
2. You are responsible for educating yourself about the details of your policy which includes deductibles, yearly maximums, and policy exclusions.
3. If the insurance company does not pay our office **within 60 days**, it is your responsibility to pay using one of the payment methods listed below. The insurance policy belongs to you and we have no leverage to obtain payment.

## Patients without Dental Insurance

If there is no insurance coverage, and pay on day of service with cash or check, you will receive a 10% discount. If you are unable to pay the full amount, you can have 3 months to pay your balance by setting up automatic payments.

## Payment Options

For your convenience, you may choose any of the following methods of payment:

- Cash
- Personal Check
- Visa, MasterCard, Discover, American Express, Debit

## Minor Patients

The parent, guardian or adult accompanying and signing all forms for a minor will be responsible for full payment. Parents or guardians must be present to authorize all dental treatment to minors.

## Financial Agreement

I understand that I am financially responsible for all charges incurred by my dependents, or myself whether or not covered by insurance. I hereby authorize the office of Dr. Lance D. Bailey to use the following signature for proof of signature on insurance claim forms for assignment of insurance payment and release of information. I agree to pay Dr. Lance D. Bailey for professional services rendered to me at the time of service. IF my insurance pays less than estimated, I agree to pay any remaining balance within 30 (thirty) days of billing. A $10.00 late fee will be charged to my account for each month a payment is not received. I expressly agree to pay all costs of collection agency fees assess at up to 50% of the total amount due, and all court costs and attorney fees, if these terms are not met.

I grant my permission to you and your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

## Failed Appointments

After 2 missed appointments, you will be charged a $75 fee and/or be dismissed from our office.

This agreement superseded all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient or Responsible Party | Print Name | Date |

*See other side for more information

**Please keep yellow copy

Thank you for choosing the office of Lance D. Bailey D.D.S!

**Available Payment Options:**

- Cash, Check, Visa, MasterCard, American Express or Discover Card, Debit Card
- We offer a 10% discount to patients who DO NOT have insurance and pay for services using cash or check on DAY OF SERVICE. We offer 5% to those who prefer to use a credit card.

Please note:

This office requires payment the day of service. We accept payment in thirds for treatments over $350, through automatic with drawl, debit or credit card. First payment must be made on the day of treatment, second payment must be made in 30 days, third payment must be made in 60 days.

A $10 late fee will be charged to your account each month a payment is not received.

For patients with dental insurance we will work with your insurance carrier to maximize your benefit and directly bill them for reimbursement for your treatment.*

The treatment plan is an ESTIMATE ONLY. Your dental plan may include limitations and exclusions that will apply. If a discrepancy occurs, YOU ARE RESPONSIBLE FOR ANY REMAINING BALANCE not paid by your insurance carrier. Discrepancies may occur due to the following: Yearly Maximums, Deductibles, Waiting Periods, Limitations and Exclusions. This estimate is only good for 90 days.

Our fee for returned checks is $30.00.

If you have any questions, please ask. We are here to help you with your dental concerns.

*If we do not receive payment from your insurance carrier within 60 days, you will be responsible for the fees and collection of your benefits directly from your insurance carrier.