



PATIENT INFORMATION

Date: NEW PATIENT UPDATE
Patient: LAST FIRST MI DATE OF BIRTH
MALE FEMALE CHILD STUDENT SINGLE MARRIED DIVORCED WIDOWED

RESPONSIBLE PARTY

Name: Date of Birth:
Address: SSN:
CITY ST ZIP CODE HOME: CELL: OTHER:
E-Mail:
Referral? Yes No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:
NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:
Address: WORK: X
CITY ST ZIP CODE

INSURANCE INFORMATION

Subscriber: LAST FIRST MI PREFERRED TITLE
Subscriber Date of Birth: Subscriber SSN:
Subscriber Employer:
Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:
Address: TEL: TOLL-FREE: FAX:
CITY ST ZIP CODE

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:
Address: TEL: TOLL-FREE:
CITY ST ZIP CODE

**MEDICAL HISTORY**

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

GENERAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR

- Y  N Are you currently under a physician's care?
- Y  N Have you been hospitalized in the past 5 years? \_\_\_\_\_
- Y  N Have you had any serious illnesses/surgeries? \_\_\_\_\_
- Y  N Do you use tobacco in any form? If Yes, Type: \_\_\_\_\_
- Y  N Do you consume alcohol? If yes, How often? \_\_\_\_\_
- Y  N Is pre-medication required before dental visits due to heart condition or artificial joint?
- Y  N Are you taking any prescription or daily OTC medications/drugs? *If yes, list details*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

FEMALE PATIENTS:  Y  N Currently nursing?  Y  N Currently pregnant? Due Date: \_\_\_\_\_

How long ago did you see a dentist? Who was your previous dentist?  
 \_\_\_\_\_

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  Y  N  
 If yes, please describe: \_\_\_\_\_

- ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):  NONE
- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> ACID REFLUX            | <input type="checkbox"/> BULIMIA                 | <input type="checkbox"/> HEART ATTACK               | <input type="checkbox"/> RADIATION/CHEMO     |
| <input type="checkbox"/> ADHD                   | <input type="checkbox"/> CANCER/MALIGNANCY       | <input type="checkbox"/> HEART DISEASE              | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> CEREBRAL PALSY          | <input type="checkbox"/> HEART MURMUR               | <input type="checkbox"/> RHEUMATIC FEVER     |
| <input type="checkbox"/> ANEMIA                 | <input type="checkbox"/> CHEMICAL DEPENDENCY     | <input type="checkbox"/> HEPATITIS                  | <input type="checkbox"/> SINUS PROBLEMS      |
| <input type="checkbox"/> ANOREXIA               | <input type="checkbox"/> CONVULSIONS             | <input type="checkbox"/> HIGH BLOOD PRESSURE        | <input type="checkbox"/> STROKE              |
| <input type="checkbox"/> ANXIETY                | <input type="checkbox"/> DEPRESSION              | <input type="checkbox"/> KIDNEY DISEASE             | <input type="checkbox"/> THYROID CONDITION   |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DIABETES                | <input type="checkbox"/> LIVER PROBLEMS             | <input type="checkbox"/> TUBERCULOSIS        |
| <input type="checkbox"/> ARTIFICIAL JOINTS      | <input type="checkbox"/> DIZZINESS/FAINTING      | <input type="checkbox"/> MITRAL VALVE PROLAPSE      | <input type="checkbox"/> ULCERS              |
| <input type="checkbox"/> ARTHRITIS              | <input type="checkbox"/> EPILEPSY/SEIZURES       | <input type="checkbox"/> MONONUCLEOSIS              | <input type="checkbox"/> VENEREAL DISEASE    |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> PACEMAKER                  |  |
| <input type="checkbox"/> AUTISM/ASPERGER'S      | <input type="checkbox"/> FREQUENT HEADACHES      | <input type="checkbox"/> PSYCHIATRIC TREATMENT      |  |
| <input type="checkbox"/> BLEEDING DISORDER      | <input type="checkbox"/> HEARING PROBLEMS        | <input type="checkbox"/> OTHER – PLEASE LIST: _____ |  |

- ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):  NONE
- |   |                                  |   |   |
|---|----------------------------------|---|---|
| <input type="checkbox"/> ASPIRIN                    | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE    | <input type="checkbox"/> SLEEPING PILLS               |
| <input type="checkbox"/> ANESTHETIC – LOCAL         | <input type="checkbox"/> DAIRY   | <input type="checkbox"/> METAL SENSITIVITY      | <input type="checkbox"/> SULFA DRUGS                  |
| <input type="checkbox"/> BARBITURATES               | <input type="checkbox"/> LATEX   | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS |
| <input type="checkbox"/> OTHER – PLEASE LIST: _____ |                                  |   |   |

Do you have any other medical conditions that we need to be aware of?  Y  N If yes, please describe:  
 \_\_\_\_\_

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES TO ANY SUBSEQUENT APPOINTMENT

Signature \_\_\_\_\_  
 (Patient, legal guardian, or authorized agent of patient)

Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_

# Consent to Proceed

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I authorize Dr. Jonathan W. Lewis and/or such associates or assistants as they 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.

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. After lengthy appointments, jaw muscles may also be sore or tender. 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 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 bronchoscopy or other procedures to ensure safe removal.

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.

Sage Creek Family Dental sends our pertinent information via text/email. I would like to receive text/email reminders and information. Please initial \_\_\_\_\_

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient, legal guardian or authorized agent of patient)



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## NOTICE OF PRIVACY PRACTICES

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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.

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### 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 02/12/2004, 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 the Notice.

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### 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 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).

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## **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 the Notice. If you request copies, we will charge you \$1. \$0.50 for each page, \$10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Jonathan W. Lewis

Telephone: (801) 871-3988 Fax: (801) 871-3988

E-mail: [sagecreekfd@gmail.com](mailto:sagecreekfd@gmail.com)

Address: 8846 S. Redwood Rd N102  
West Jordan UT 84088



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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I have had the opportunity to read and or receive a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name (Patient, legal guardian or authorized agent of patient)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

<b>For Office Use Only</b>
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We attempted to obtain written acknowledgment 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Financial Guidelines

*We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.*

### Insurance

**We accept most major dental insurance policies, however we may not be an in network provider for your plan.** If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.
- **Minors must be accompanied by a parent or legal guardian.** If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

### Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
  - o All major credit cards are accepted (Visa, MasterCard, American Express, Discover)
  - o 10% Discount for our uninsured cash/check paying patients
  - o Financing options with CareCredit®
- **Balances left over 90 days will incur an 18% or \$10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

### Short Cancelled/ Missed Appointments

- We request a **24 hour** notice for all cancellations or rescheduled appointments. If we are not given adequate notice, you will be subject to a **\$50** broken appointment fee. We are aware that unforeseen events sometimes require missing an appointment. These events will be reviewed by the office management. Thank you for your cooperation.

**By signing below I acknowledge I have read and understand the guidelines above.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_