

PATIENTS NAME	DATE
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Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe		Yes No
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Do you have dental examinations done on a routine basis? Last visit	Yes	No
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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? Discuss	Yes	No
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Does food catch between your teeth? Any loose teeth?	Yes	No
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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): _____ Yes No

Date of last full mouth x-rays (16 small films or panoramic):		Yes	No

Medical History

Are you under of 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 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 ☐ Latex ☐ 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 your medication may be required.

[illegible]

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 medications change, I shall inform the dentist and staff at the appointment without fail.

X _____ Date _____

Patient Signature (PARENT OF GUARDIAN)

Reviewed by Doctor _____ Date _____

History Review and Significant Findings

Medical Updates

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

Date	Exceptions	Patient Signature	Review By:
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**NOTICE OF PRIVACY PRACTICES OF
SANFORD HAMILTON D.M.D. AND SHAWN HAMILTON D.M.D.**

**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 took 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 a new Notice 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.

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 health care 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 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 projected information if the disclosure is made for purpose 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 office. List, if request, will be \$__ for each page and the staff time charged will be \$__ per hour including time required to locate and copy of your health information. Please contact our 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 of 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 out of our 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 statement 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 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 judgement to disclose only that information directly relevant to your care. We will also use our professional judgement 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 healthcare 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 requests 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.

Sanford Hamilton Shawn Hamilton

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 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 of our patients. We accept Cash, Check, Visa, Master Card, Discover Card and American Express.

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 deductible in full at the time of services. **IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES IN YOUR INSURANCE COVERAGE.**

Missed Appointment

In order to be fair to all of 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 are unable to keep your scheduled appointment.

Finance Charges and 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. Hamilton must take additional steps to collect my balance, I will pay fees incurred by Dr. Hamilton including collection agency fees and attorney's fees.

Permission to Contact Via Cell Phone

I authorize Dr. Hamilton, or any other person or entity who provides goods or services in connection with this agreement, to contact me regarding servicing and 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 cell, or any other wireless telephone numbers I have or may obtain. I also authorize you to contact me by text message, 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 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, Wednesday, Thursday from 8 am to 5 pm and Friday 8 am to 12 pm.***

Signature: _____ **Date:** _____

Sanford Hamilton D.M.D

Shawn Hamilton D.M.D.

1683 West 6235 South

Taylorsville, UT 84123

(801)264-0617

www. Hamiltondentalutah.com

NAME _____

HEALTH QUESTIONARIE ACKNOWLEDGEMENT AND CONSENT TO PROCEED. I understand that the answers to the health questionnaire are accurate and correct to the best of my knowledge. Since a change in medical conditions 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. Hamilton 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 agents(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 can 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 risks 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 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 INFORMATION DATE _____

NAME _____ ☐ MALE ☐ FEMALE
Last First Middle Name
SOCIAL SECURITY# _____ ☐ MARRIED ☐ SINGLE ☐ DIVORCED

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 _____

INSURANCE INFORMATION Employer Phone & Address _____

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/YR)			RELATIONSHIP	BIRTHDATE (MO/DAY/YR)			RELATIONSHIP
EMPLOYER		DENTAL INSURANCE CO.		EMPLOYER		DENTAL INSURANCE CO.	
SS#	SUBSCRIBER		PHONE #	SS#	SUBSCRIBER		PHONE #

EMERGENCY CONTACT (Other than immediate family) REFERRAL INFO: How did you hear about of office?

Name _____

City/State/Zip _____

Telephone _____

AUTHORIZATION METHOD OF PAYMENT

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 health professionals.

X _____
Responsible Party

Card # _____ Exp. Date _____
☐ Payment in full at each appointment (☐ Visa ☐ MC ☐ Other)
☐ Payment in full at each appointment (cash or personal check)

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 balance (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. Hamilton 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 collection agency I will pay a collection fee.

Date: _____ State Driver's License # _____

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 to sweets? YES/NO

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

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