The Dental Studio
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FOR OFFICE USE ONLY

Guest Information

Date of Last Dental Visit: _____

Guest Name:_____ Date_____
Last, First MI (Preferred Name)

Gender:_____ Family Status:_____

Social Security #:_____ Birth Date:_____

Phone (Home):_____ (Mobile): _____

Address: _____
Street Apartment #

_____ _____
City State Zip Code

E-mail address:_____

Medical Alerts:

PLACE A CHECK IN THE YES OR NO COLUMN AND ANSWER QUESTIONS.	*YES*	*NO*
1. Do you consider yourself to be in good health?		
2. Are you in pain at this time?		
3. Have you ever had hepatitis, Liver disease, or "yellow jaundice"?		
4. Have you ever had an unusual reaction or are you allergic to any of the following drugs Penicillin____;Aspirin____;Acetominophen____;Ibuprophen____;Codeine;____;Barbiturates____;Sulfa Drugs___: Local Anesthetic Other:_____		
5. Do you have any other allergies? If yes describe:		
6. Are you presently taking any medicines (including the birth control pill) or supplements: If yes, specify name, dose and purpose of medication. (attach list if needed)		
7. Do you **smoke** cigarettes, cigars, or chew tobacco?		
8. Do you **drink alcoholic** beverages (including coolers)?		
9. Do you **get short of breath** after climbing 1 flight of stairs?		
10. Do you have or have you ever had any **heart or blood problems**?		
11. Have you ever been told that you have **a heart murmur**?		
12. Do you **require antibiotic pre-medication** for a heart condition, **artificial valve or artificial joint**?		
13. Do you bleed or **bruise easily**?		
14. Do you have or have you ever had **high blood pressure**?		
15. Are you a "bleeder" or have you had **excessive bleeding** following dental or other surgery?		
16. Have you ever been diagnosed as being **HIV positive** or having AIDS?		
17. Have you ever had any **severe reaction** to dental treatment or local anesthetics?		
18. Are you **subject to fainting**?		
19. Have you ever **had a nervous breakdown** or undergone **psychiatric treatment**?		
20. (Female only) Are you **pregnant or possibly pregnant**?		
21. **Do you think that your teeth are affecting your general health in any way**?		
22. Do you have or have you ever had **bleeding or sensitive gums**?		
23 Do you **snore** at night or **grind your teeth** or are you being treated for **sleep apnea**?		
24. Have you ever taken Bisphosphonates (Fosomax, Boniva, etc.) or had osteonecrosis of the jaw.		
25 Have you ever taken "Phen-Fen" or similar appetite suppressants? If yes, have you seen your physician cardiologistfor a cardiac evaluation? Yes/No please circle		
26. How long ago did you last see a last dentist and why did you not return.		
27. Who was your previous dentist? Phone:		

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Have you ever had any of the following?

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
  Please include the name of physician even if not currently under treatment
- Are you currently under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Emergency Contact: _____ Phone: _____
  Relationship to patient:_____

Heath Questionnaire Acknowledgement and 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. David S. Peterson 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 agents(s), including those related to restorative, palliative, therapeutic or surgical treatments. I consent and authorize Dr. David S. Peterson, DDS to take x-rays, make study casts, photographs, videos or any other image, with or without my name, for education, teaching, advertising, or other lawful purpose and I forever release him from any claim or demands as to there use.

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, and temporary or rarely, permanent numbness and muscle soreness. I do voluntarily assume any and all possible risk, 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.

Mediation/Arbitration agreement:
Should any claim or controversy arise between the guest and/or a legally authorized representative of the guest and the dentist concerning the care and treatment rendered by the dentist to the guest, an effort shall be made by the parties involved to resolve the dispute through mediation according to the rules of WESTERN MEDIATION, should the dispute pertain to the quality of the dental services rendered. Thus a claim or controversy shall first be submitted to non-binding mediation. Cost for the mediation services shall be shared equally by the parties involved. The foregoing mediation agreement does not pertain to actions taken for the collection of debts owed as a result of dental services rendered.

Date «FirstVisit»	Signature of Guest, Legal Guardian or agent
Date «FirstVisit»	Signature of Doctor

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Referral Information

Whom may we thank for referring you to our practice? ☐ Another guest, friend ☐ Another guest, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ___

Name of person or office referring you to our practice: _____

Employment Information

The following is for: the guest or the person responsible for payment

Employer Name:_____ Occupation: _____

Address:_____

_

Street City, State Zip Code Phone

Reimbursement (insurance) Information

Primary

Name of Insured: _____ Is insured a guest? Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Guest's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: «PIns_Name»

Secondary

Name of Insured: _____ Is insured a guest? Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Guest's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

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Financial Terms for Service

As validated by my signature on the bottom of this form, I understand that the Dental Studio of DAVID S. PETERSON DDS, FAGD depends upon reimbursement from guests for the costs incurred in their care. Financial responsibility on the part of each guest must be determined before treatment in most circumstances.

Summary:

In consideration of the professional services rendered to me, or at my request, by David S. Peterson DDS, FAGD, or any associated with him, I agree to pay therefore the reasonable value of said services to David S. Peterson DDS, FAGD at the time said services are rendered. I further agree that the reasonable value 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 time 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. I grant my permission to David S. Peterson DDS, FAGD or his assignee, to telephone me at home or at my work to discuss matters related to this form.

We are eager to help each of our guests with their dental needs. The above policies are subject to periodic change without notice. You are responsible for payment in full regardless of any third party company's determination of usual and customary rates (UCR). Please talk with your treatment coordinator if you have any specific concerns. A service charge of at least 1.50% per month (18% APR) will be charged on overdue accounts or when considered in default by DAVID S. PETERSON DDS, FAGD. In case of default, I agree to pay all costs for collection including but not limited to arbitration/mediation costs, attorney fees, and court costs in addition to my unpaid balance. A collection fee of at least 100% of the unpaid balance will be added to my balance if my account is turned over to collections.

All treatment cases exceeding $1500 must be paid for 72 hours prior to procedure date. This can be paid for by credit card, cash, check, or Care Credit financing.

I have read the above Practice Philosophy and financial conditions of treatment and payment and agree to their content.

_____ Date: _____

Signature of guest, parent or guardian

Relationship to Guest: _____

VIP CHECKOUT

Type of Card: _____

Card Number: _____ Security Code :_____

Signature of card holder: _____

Printed name on Card:_____

Expiration Date: _____

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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.

_____
{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)

_____

_____

_____

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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 (11/01/2006), 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 may charge you $0.50 for each page, $45.00 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.

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. We will provide you with the address to file your complaint with 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: David S. Peterson DDS, FAGD
Telephone: 801-278-4787 Fax: 801-424-4241
E-mail: smileutahstudio@gmail.com
Address: 6556 S. Big Cottonwood Canyon Rd., STE 500A, Salt Lake City, Utah 84121

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Telephone: _____ E-mail: _____

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.

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 any revisions of our Notice, at any time by contacting:

Contact Officer: David S. Peterson DDS, FAGD
Telephone: 801-278-4787 Fax: 801-424-4241
E-mail: smileutahstudio@gmail.com
Address: 6440 Wasatch Blvd, STE 140, Salt Lake City, UT 84121

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 heath care operations.

Signature: _____ Date: «FirstVisit»

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

Personal Representative's Name: _____

Relationship to Patient: _____

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REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: «FirstVisit»

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BROKEN APPOINTMENT POLICY

When you make a dental appointment at our office, a specific time, room and materials are reserved for you to see the dentist or hygienist. Cancelled/missed appointments result in a loss of valuable time and resources that are very costly to our office and prevents other patients from getting reservations.

For this reason, if a patient fails to keep a reserved appointment he or she will be charged a fee of **$75 per hour for a cancelled/ missed appointment**. It is the patient's responsibility to keep their scheduled appointment.

If an appointment needs to be rescheduled for any reason, please notify our office at least 48 hours in advance of the appointed time. As a courtesy, no cancelled appointment fee will be charged.

We offer automated reminders through email and texts on your cell phone. They are given 3 weeks in advance, 3 days in advance and 1 hour before your appointment. Our goal is to give our patients the highest quality of dentistry. In order to give you superb customer service, please come to your appointments on time so we can give you the full attention that you deserve as one of our patients.

Thank you for your cooperation.

Signed:_____Date: «FirstVisit»
(Patient)

Cell phone: «HPhone» E-mail:«EMailAddress»

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INFORMED CONSENT FOR THE USE OF OZONE TREATMENT

Dental oxygen/ozone has been shown to be an effective anti-bacterial, anti-fungal and anti-viral treatment agent as it creates a therapeutic oxygen rich environment. It increases circulation and oxygenation to the treatment area. It increases the immune response and creates an environment for the production of anti-oxidants. It is a circulatory stimulant, a wound-cleanser, an accelerant for wound healing and a haemostatic agent. Ozone/oxygen therapy could be useful to kill pathogenic bacteria on the surface of the tooth which allows enamel to re-mineralize naturally, to kill pathogenic bacteria which disinfects deep gum pockets, to allow the body to build bone around teeth and kill the bacteria, and to clean the tooth before the filling is put in, especially in deeper areas. By signing this document, you give Dr. David Peterson permission to apply ozone to your tooth or teeth, gingival (gums), area of oral irritation, and/or sore or problem area.

Ozone is a molecule of three oxygen atoms. Ozone has been shown to be safe and effective for the reduction of bacteria, virus, and fungus. It is more effective than chlorine based disinfection agents and has the ability to decompose or break down into oxygen which is far safer than the by-products of chlorine based disinfectant when it breaks down. The bottled water industry typically uses Ozone as the last treatment to the water prior to bottling, as Ozone will disinfect and usually break down in a short period of time. There are uses for Ozone in medically related treatments. Currently, Ozone is NOT approved by the FDA for dental treatment. Ozone is currently being used in Europe, South Africa, Asia and Canada in connection with dental treatment. It has shown its effectiveness in minimally invasive dental procedures to assist in the reduction of tooth sensitivity, gum line pockets, gum line irritation, halitosis (bad breath) and has been shown to assist in the reversal of the decay process in shallow, initial cavities (without the need for anesthetic, drilling or filling). In cases where ozone is not effective or when the patient chooses not to have ozone therapy, other dental treatment may be performed or may be necessary. This treatment, usually at higher cost, may be performed by Dr. Peterson. These types of treatments include, but are not limited to: larger and/or deeper fillings, crowns or caps, root canal treatment, tooth extraction, oral or periodontal gum surgery.
The success of any dental treatment is often dependent upon a variety of factors which may or may not be in anyone's control. These factors may include, but are not limited to: duration of the existing problem, severity of the problem, and health status and healing ability of the patient.

[ ] I have chosen to have Ozone treatment [ ] I have chosen NOT to have Ozone treatment

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of ozone treatment and have received answers to my satisfaction. I have been given the option of seeking with a specialist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Peterson and/or his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Name:_____

Signed:_____ Date: / / .

Witness:_____

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