PATIENT INFORMATION

NAME____________________ DATE OF BIRTH____________ SS#______________

ADDRESS____________________ CITY/ZIP______________ HOME#___________

EMPLOYER________________________ ADDRESS________________________

WORK PHONE____________ CELL PHONE____________ EMAIL______________

PLEASE TELL US, WHO REFERRED YOU TO OUR OFFICE? ______________________

WHO IS YOUR GENERAL DENTIST? ______________________________

Reason for visit ☐ Gum Graft/ Recession ☐ Implant ☐ Crown Lengthening ☐ Perio pocketing ☐ Other

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME____________________ DATE OF BIRTH____________ SS#______________

ADDRESS____________________ CITY/ZIP______________ HOME #___________

EMPLOYER________________________ ADDRESS________________________

WORK PHONE ______________ CELL PHONE ________________

SPOUSE OF RESPONSIBLE PARTY

NAME____________________ DATE OF BIRTH____________ SS#______________

ADDRESS____________________ CITY/ZIP______________ HOME #___________

EMPLOYER________________________ ADDRESS________________________

WORK PHONE ______________ CELL PHONE ________________

NEAREST LIVING RELATIVES (NOT LIVING WITH YOU)

NAME__________________ RELATIONSHIP____________ PHONE____________

NAME__________________ RELATIONSHIP____________ PHONE____________

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INS.____________________ ADDRESS____________________

PHONE________________ POLICY#______________ GROUP#______________

NAME OF POLICY HOLDER____________________ BIRTHDATE______________

SECONDARY DENTAL INS.____________________ ADDRESS____________________

PHONE________________ POLICY#______________ GROUP#______________

NAME OF POLICY HOLDER____________________ BIRTHDATE______________

HEALTH HISTORY

PATIENT NAME: ____

1. Name of Physician:______________________________Phone______________
2. Date of last physical examination_______________________________________
3. Are you in good health?..YES NO
4. Have you had surgery or x-ray treatment for a tumor, growth and or other condition of the head, mouth, or lips?..YES NO
5. Are you under the care of a physician for any medical problems?............................ YES NO
6. Have you ever had any serious illness or major operations?....................................YES NO
7. Are you taking any medications regularly? (Prescription or over the counter)........... YES NO
   If so please list____

   ____
8. Have you had an adverse reaction or allergy to any following?
   - Aspirin..YES NO
   - Dental anesthetics.. YES NO
   - Anti-inflammatory medications.. YES NO
   - Penicillin or other antibiotics... YES NO
   - Codeine or other pain medications..YES NO
   - Latex materials... YES NO
9. Are there any medications you cannot take?..YES NO
   If so please list____
10. Have you ever had abnormal bleeding or difficulty with clotting after a wound?...........YES NO
11. Have you ever had an unfavorable reaction following dental treatment?....................YES NO
12. Do you smoke or chew tobacco at the current time & how much in a day? ____________
13. Have you ever smoked or chewed, and how long?
14. Do you have or have you ever had any of the following:

Alcoholism/Drug Dependency	Heart trouble of any kind	Prosthetic cardiac valves
Artificial Joints/prosthetic implants	Heart murmur	Radiation therapy
Asthma	Hepatitis/Jaundice	Rheumatic fever
Bacterial Endocarditis	High/low blood pressure	Seizures or convulsions
Cancer	HIV positive/Aids	Stroke
Cardiovascular Disease	Kidney problems	Syncope/Tendency to faint
Diabetes	Mitral valve prolapse	Tuberculosis
Emphysema	Organ transplant	Ulcers
Epilepsy	Pacemaker	STD
Glaucoma	Phen/fen	

Have you ever taken Fosamax, Actenol, Boniva, or any drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? YES NO

15. Do you have any other serious illness?..YES NO
16. Are you taking female hormones (oral contraceptives, etc.)?..YES NO
17. Are you pregnant trying to become pregnant of nursing at the present time?............ YES NO

HEALTH 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 subsequent appointments.

Date: _____________Patient Signature: ______________________________________

Update: ___________Patient Signature: ______________________________________

Update:____________Patient Signature: ______________________________________

Update:____________Patient Signature:_______________________________________

Reviewed by: ____ Date: _________

DENTAL PAYMENT AGGREEMENT

Dr. Paul O. Francis

Payment is required when services are rendered. You insurance policy is a contract between you and your insurance company. Insurance companies often set fees that are below our customary charges. You are still obligated for the full amount. Some companies pay fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. We encourage patients to "assign benefits" directly to themselves for insurance claims while paying completely for treatment at the time of service. We will offer to file all insurance claims for the patient as a convenience: however, you are responsible to know your benefits and coverage. Any fees not paid by the insurance within 60 days will be billed to patient.

Multiple Visit Payment Options

Option 1: Full Pre-payment of fees by check or cash (5%courtesy fee reduction for payment before treatment is rendered)
Option 2: Full payment of fees at the time of service
Option 3: Outside financing of treatment.
For those who would prefer an extended payment plan, outside financing is available through Care Credit. These plans allow you up to 12 months of no interest payments. Extended payment plans beyond 12 months are also available at reasonable interest rates. Please visit Care Credit online at www.carecredit.com/patients/whatis.htm for further information or ask for a brochure from our receptionist.

Missed Appointments

I understand that I will be assessed $30.00 per half hour scheduled for failure to keep an appointment or notify the dental office of a cancellation 24 hours in advance. Out intent is not to add financial burden, but to improve accessibility to patients desiring periodontal care. **When scheduling for a surgery appointment we may ask for a deposit to reserve your appointment. This may not be refundable if you fail to give us 48 hours cancellation.**

I grant my permission to your office to telephone me at home or work to discuss matters related to this form. I have read the entire Financial Agreement and have had sufficient time to study and understand it, or obtain legal counsel, if I so desire. I herby agree to be bound by the foregoing terms and conditions outlined hereon. In the event that the terms of the agreement are not met, I agree to pay the principal amount, plus all attorney's fees, court costs, collection costs, including 50% of the principal amount not current, i.e. after the 1st 30 days, There will be a %15 statement fee accessed each month if payment is not made.

I authorize the release of any dental or other information necessary to process this claim. I also request and authorize payment of benefits to Paul O. Francis DDS, MS, LLC.

Please understand that your first consultation is free. However, if you do accept treatment the above terms apply and we are asking that you sign this form at this time.

Signature: ____ **Date:** ________________

We accept all major credit cards, cash and personal checks ($25 returned check fee)

Alpen Periodontics & Implant Dentistry
Paul O. Francis, DDS, MS
3300 N Running Creek Way, Bldg. C, Suite 300, Lehi, UT 84043

PATIENT CONSENT/DISCLOSURE AND NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Carefully review and sign where appropriate.**

Alpen Dentistry will only use patient healthcare information for treatment, payment and healthcare operation purposes. We reserve the right to change our privacy practices and the terms of this Notice at any time for all health information that we maintain, including health information we created or received before we made the changes. You may request a copy of our Notice at any time by notifying Alpen Dentistry in writing.

Treatment: It may be necessary to share patient health information with other dentists or medical/dental facilities. This may include specialists and primary care physician/providers.

Payment: The release of patient health information may become necessary to determine eligibility, coverage, claim adjudication, billing, collection, medical/dental necessity, utilization reviews, and to obtain payment for services we provide to you.

Healthcare Operations: Alpen Dentistry will protect patient health information by accessing information that is reasonable and documenting disclosures, speaking quietly and sharing health information outside of the practice where necessary to provide optimum healthcare operation including conducting training programs, certification, licensing and credentialing activities. Contacting a patient regarding appointments and transmitting relevant information about health services is a part of healthcare operations.

Family and Friends: We must disclose your health information to you, as described in 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 you with your healthcare or with payment for your healthcare.

Persons Involved in Care: Alpen Dentistry may use or disclose health information to notify, or assist in the notification (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. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment including prescriptions, medical supplies, x-rays, or other similar forms of health information
.

Your Authorization: You may revoke your authorization of our use of your health information for treatment, payment or healthcare operations, **in writing**, at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We may not disclose your health information for any reason except as noted
.

Required by Law: We may use or disclose your health information as 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, domestic violence or 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written notice.

PATIENT RIGHTS: The patients of Alpen Dentistry have the following rights regarding their healthcare information:

1. To request restriction on the policies as defined in the Notice of Privacy Practices. A written request must be submitted to the office manager requesting restrictions **except in an emergency.**
2. The right to access, inspect, copy and amend his or her own records. The patient must sign a "Release of Medical Records" consent. If you decide to request copies health information will be provided at a charge of $20 per hour for staff time and a charge of $.75 per page plus postage.
3. The right to receive a listing of all information disclosures upon request at the above listed cost basis per request.
4. The right to receive a paper copy of the privacy notice upon request.
5. The right to revoke the lifetime consent and financial policy in writing at any time.
6. The right to file a complaint with the practice and/or the Department of Health and Human Services if you feel that your privacy rights have been violated.
7. If you received this Notice on our Web site or electronically, you are entitled to receive this Notice in written form.

Contact Person: ALPEN DENTISTRY (801) 766-6966
FAX: (801) 766-6967
www.francisperio.com

**The word "patient" in the above document may mean legal guardian or legally authorized person.

I, ______________________________ have had full opportunity to read and consider the contents of this Consent form and 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 healthcare operations.

This form needs to be signed in order for us to contact your Dental and Medical doctors and or their staff to develop a treatment plan for you benefit.

Signature: ____

Printed Name: ____

Date: ________________________