ACQUAINTANCE FORM

Patrick M. Tanner D.M.D.

Restoring Smiles, Preserving Health

Date: _____

Patient Name: _____Single____Married____Widowed____Divorced____

Address: _____

E-Mail Address:_____Birth Date:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Social Security No.:_____

Employer:_____Occupation:_____

Person Responsible for Account:_____

Emergency Contact (Name, Phone Number & Relationship)_____

How did you hear about Dr. Tanner? _____

Whom may we thank for this referral? _____

Do you have dental insurance? ____Yes ____No If yes, please complete the insurance information.

Insured's name:_____ Date of Birth:_____

Social Security Number or Subscriber Id:_____

Dental Insurance Name:_____ Phone No.:_____

Group No.:_____Insured's Employer:_____

1.. Have you been under the care of a medical doctor during the past two years?___Yes___No

Physician's Name & Phone Number:_____

2. Are you now taking any medications, drugs, or pills? ___Yes___No List _____

_____

3. Are you now taking any vitamins, supplements, or herbal therapy? ___Yes___No List _____

4. Are you allergic to any medications? _____Yes _____No If yes, please list _____

_____

5. Check any of the following which you have had, or have at the present time:

__AIDS	__HIV positive	__Respiratory Problems	__Rheumatic Fever	__Allergies/Hives	__Diabetes
__Heart Surgery	__Rheumatism	__Glaucoma	__Low Blood Pressure	__Hemophilia	__Scarlet Fever
__Angina Pectoris	__Hepatitis A	__Emphysema	__High Blood Pressure	__Artificial Joints	__Epilepsy
__Arthritis	__Hepatitis B	__Cancer	__Fainting / Dizzy Spells	__Seizures	__Sinus / HayFever
__Stroke	__Hepatitis C	__Leukemia	__Blood Transfusion	__Bruise Easily	__Anemia
__Liver Disease	__Heart Disease	__Chemotherapy	__Mitral Valve Prolapse	__Syphilis	__Thyroid
__Cold Sores	__Heart Failure	__Radiation	__Cortisone Medicine	__Tuberculosis	__Ulcers
__Heart Murmur	__Heart Attack	__Nervousness	__Venereal Disease	__Psychiatric Trxt	__Drug Addiction
__Yellow Jaundice	__Pacemaker	__Pain in Jaw Joints	__Phen-Phen/Redux	__Head Aches	__Other

6. Do you have any disease, condition, or problem not listed? ___Yes___No

If yes, please

list_____

7. **Women only** Are you pregnant or think you may be? ___Yes___No

8. **Women only** Are you taking birth control pills? ___Yes___No

DENTAL HISTORY

Please check any of the following problems that apply to you.

____Sensitivity (hot, cold, sweet)
____Tooth pain or discomfort when chewing
____Headaches, earaches, neck pain
____Jaw joint pain
____Teeth or fillings breaking
____Grinding or clenching teeth
____Bleeding, swollen or irritated gums
____Loose, tipped or shifting teeth
____Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

____Dentures
____Partial dentures
____Braces
____Periodontal (gum) treatment

Please share the following dates:

Your last cleaning:_____Your last oral cancer screening_____Your last complete X-Rays_____

Name of Previous Dentist:_____

If you could whiten your teeth for a cost anyone could afford, would you do it?_____

Do you smoke or use chewing tobacco? How much? For how long?_____

If you could change your smile, you would?

____Make them brighter
____Make them straighter
____Close spaces
____Replace black metal fillings with natural, tooth-colored filling
____Repair chipped teeth
____Replace missing teeth
____Replace old crowns that don't match
____Have a smile makeover

On a scale of 1 – 10, with 10 the highest rating: How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?_____

What is the most important thing to you about your future smile and dental health?_____

What is the most important thing to you about your dental visit today?_____

CONSENT TO PROCEED

I authorize Dr. Tanner 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 treatment.

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 bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist 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 substantial and significant risk of serious harm, if any, which may be associated with any phase of 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.

I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. In the event of default, I(we) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees, as may be required, to collect on this note.

Patient Name:_____

Signature:_____ **Date:**_____

(Patient, legal guardian or authorized agent of patient)

Witness:_____ **Date:**_____

HIPAA Notice of Privacy Practices

Patrick M. Tanner, D.M.D.

South Ogden Smiles

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected dental information (PDI) to carry out treatment, payment or dental care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected dental information. "Protected dental information" is information about you, including demographic information that may identify you and that relates to your past, present or future dental health condition and related dental care services.

1. Uses and Disclosures of Protected Dental Information

Your protected dental information may be used and disclosed by your dentist or office staff and others outside of our office that are involved in your care and treatment for the purpose of providing dental care services to you, to pay your dental care bills to support the operation of the dentist practice, and any other use required by law.

Treatment: We will use and disclose your protected dental information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party. We will also disclose to a family member, spouse, or adult children, any information necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extent necessary to help with your dental care and/or with payment for your dental care. For example: we would disclose your protected dental information, as necessary, to a home health agency that provides care to you. Another example would be when information needs to be shared with a specialist or a physician to whom you have been referred, thus ensuring the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your protected dental information will be used as needed to obtain payment for your dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected dental information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected dental information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected dental information to dental/hygiene students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected dental information as necessary to contact you to remind you of your appointment via mail, e-mail or by phone.

We may use of disclose your protected dental information in the following situations without your authorization: These situations include; as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your rights: Following is a statement of your rights with respect to your protected dental information.

You have the right to inspect and copy your protected dental information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected dental information that is subject to law that prohibits access to protected dental information.

You have the right to request a restriction of your protected dental information: This means you may ask us not to use or disclose any part of your protected dental information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected dental information not be disclosed to family members or friends who may be involved in your

care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected dental information, your protected dental information will not be restricted. You then have the right to use another Dental care Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected dental information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected dental information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your for filing a complaint.**

This notice was published and became affected on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected dental information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number 801-475-7776.

I, _____, have received a copy of the above Notice of Privacy Practices from South Ogden Smiles and give my permission to all of the above.

_____ _____

Signature Please Print Name Date

You may refuse to sign this acknowledgement

If refusing: _____

Signature Date