CORNER CANYON
Aesthetic Dentistry

Date _____ **PATIENT INFORMATION AND HEALTH HISTORY**

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

PERSONAL INFORMATION

PATIENT NAME _____
FIRST MIDDLE LAST

PATIENT DATE OF BIRTH _____ PATIENT SS# _____-_____-_____

HOME ADDRESS _____ HOME PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ BUS. PHONE ( ) _____ ext____

PATIENT EMPLOYED BY _____ CELL PHONE ( ) _____

BUSINESS ADDRESS _____ CITY _____ ZIP _____ E-MAIL_____

NEAREST RELATIVE/
EMERGENCY CONTACT _____ PHONE ( ) _____ CELL ( ) _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR SERVICES? YES _____ NO _____
(If no skip to dental information)

DENTAL INSURANCE INFORMATION

NAME OF YOUR DENTAL INSURANCE COMPANY _____ Gp# _____

NAME OF SUBSCRIBER _____ YOUR RELATIONSHIP TO SUBSCRIBER SPOUSE ❑ CHILD ❑ SELF ❑

SUBSCRIBER DATE OF BIRTH _____ INSURED SS# _____-_____-_____

EMPLOYER _____ BUS. PHONE ( ) _____

BUSINESS ADDRESS _____ CITY _____ ZIP _____

SECONDARY DENTAL INSURANCE COMPANY

NAME OF INSURANCE COMPANY _____ Gp# _____

NAME OF INSURED_____

INSURED DATE OF BIRTH _____ INSURED SS# _____-_____-_____

INSURED EMPLOYER_____ BUS. PHONE ( ) _____

DENTAL INFORMATION

DO YOUR GUMS BLEED WHEN YOU BRUSH/OR FLOSS? YES _____ NO _____

DO YOU HAVE CHRONIC BAD BREATH? YES _____ NO _____

ARE YOUR TEETH SENSITIVE TO HEAT OR COLD? SWEETS? OR BITING DOWN? YES _____ NO _____

DO YOU GRIND OR CLENCH YOUR TEETH? YES _____ NO _____

HAVE YOU EVER HAD A BAD DENTAL EXPERIENCE? YES _____ NO _____

DATE OF LAST EXAMINATION _____ DATE OF LAST X-RAYS _____

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH? WOULD YOU LIKE TO IMPROVE THEM? _____

_____

HOW WOULD YOU DESCRIBE YOUR CURRENT DENTAL PROBLEM? _____

_____

HOW WOULD YOU LIKE TO SEE US CORRECT YOUR DENTAL PROBLEM?

_____

_____

For your health's sake, you must be accurate:

Physician Name_____

Phone _____ **MEDICAL HISTORY**

CIRCLE

1. Have you been a patient in the hospital during the past two years? _____ YES NO
2. Have you been under the care of a medical doctor during the past two years? _____ YES NO
3. Have you taken Phen-Fen during the past two years? _____ YES NO
4. Have you had an EKG? _____ YES NO
5. Have you ever been advised to pre-medicate prior to dental treatment?_____ YES NO
6. Are you allergic to penicillin, aspirin, codeine, latex or other (please circle or list)? _____
7. List any medications you are taking_____
8. Have you ever had excessive bleeding requiring special treatment?_____ YES NO
9. Circle yes or no for each of the following which you have had or have at present.

Heart Failure	YES	NO	Ulcers	YES	NO	AIDS	YES	NO
Heart Disease or Attack	YES	NO	Emphysema	YES	NO	Hepatits A (infectious)	YES	NO
Angina Pectoris (Chest Pains)	YES	NO	Chronic Bronchitis	YES	NO	Hepatitis B (serum)	YES	NO
High Blood Pressure	YES	NO	Tuberculosis	YES	NO	Liver Disease	YES	NO
Heart Murmur	YES	NO	Asthma	YES	NO	Blood Transfusion	YES	NO
Rheumatic/Scarlet Fever	YES	NO	Hay Fever/Sinus Trouble	YES	NO	Drug or Alcohol Abuse	YES	NO
Conginital Heart Lesions	YES	NO	Allergies or Hives	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Diabetes	YES	NO	VD (Syphilis, Gonorrhea)	YES	NO
Mitral Valve Prolapse (MVP)	YES	NO	Thyroid Disease	YES	NO	Cold Sores	YES	NO
Heart Pacemaker	YES	NO	X-ray or Cobalt Treatment	YES	NO	Genital Herpes	YES	NO
Heart Surgery	YES	NO	Chemo (Cancer, Leukemia)	YES	NO	Epilepsy or Seizures	YES	NO
Artificial Joints	YES	NO	Arthritis	YES	NO	Fainting or Dizzy Spells	YES	NO
Anemia	YES	NO	Cortisone Medicine	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Glaucoma	YES	NO	Psychiatric Treatment	YES	NO
Kidney Trouble	YES	NO	Pain in Jaw Joints	YES	NO	Bruise Easily	YES	NO

10. Do you ever wake up from sleep short of breath? _____ YES NO
11. Are you on a special diet? _____ YES NO
12. Has your medical doctor ever said you have a cancer or tumor? _____ YES NO
13. Do you have any disease, condition or problem not listed? _____ YES NO
14. WOMEN: Are you pregnant now? _____ YES NO
    Do you anticipate becoming pregnant? _____ YES NO
    Are you taking birth control? _____ YES NO

Please be advised that many antibiotics may lessen the effects of oral contraception.

Please describe 'yes' answers_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. I understand that the doctor reserves the right to charge $100.00 for appointments cancelled or broken without 24 hour advance notice.

DATE _____ SIGNATURE _____

I hereby grant complete authority to Dr. Day to administer any treatment and to administer such x-rays, anesthetics, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

DATE _____ SIGNATURE _____

_____

_____

Corner Canyon Aesthetic Dentistry

Paul A. Day, D.D.S.

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Corner Canyon Aesthetic Dentistry, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of our services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records , we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (801) 495-4440.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of the Notice of Privacy Practices. Date: _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

CORNER CANYON
Aesthetic Dentistry

I _____ understand that I am responsible for all charges to myself and/or dependent children regardless of insurance status and therefore guarantee payment to Corner Canyon Aesthetic Dentistry.

I also understand that any benefits quoted to myself or Corner Canyon Aesthetic Dentistry by a representative of my insureance compnay is not a guarantee of payment and I am responsible for all amounts not paid by my insurance.

Signature _____
Date _____