LONE PEAK **DENTAL**
M. Sean Lorscheider DMD

Please complete the following Patient Registration Form

STEP 1 PATIENT INFORMATION

If this appointment is for **YOU**, please start here:

Today's Date

Name Sex

Street Address

City State Zip Code

Home Phone # Work Phone #

Email Address

Drivers License # Birthdate SS# - -

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If this appointment is for your **CHILD**, please start here:

Today's Date

Name Sex

Street Address

City State Zip Code

Home Phone # Birthdate Age

School Grade

STEP 2 INSURANCE INFORMATION

Group #

Dental Insurance Company Phone #

Street Address

City State Zip Code

Employer Phone #

Insured Employee Name Birthdate

Date Employed Insured Employee SS# - -

STEP 3 PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name

Address City State Zip

Home Phone # Cell Phone # Work Phone # Ext.

SS # - - Drivers License #

Employer Work Address

Spouse's Name Employer

Work Address Work Phone #

STEP 4 GETTING TO KNOW YOU

Whom may we thank for referring you to our office?

What are your hobbies & interests?

Is there anything you'd like to change about your smile?

Are any members of your family currently Lone Peak Dental patients? ☐ YES ☐ NO

Their Name

Address

City State Zip

STEP 5 EMERGENCY CONTACT INFORMATION

Name of an individual you would like us to contact in an emergency

Street Address

City State Zip Code

Home Phone # Work/Cell Phone #

Closest relative NOT living with you

Address City State Zip

Home Phone # Work/Cell Phone #

STEP 6 PLEASE READ - OFFICE POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (*the amount **not** covered by insurance*) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance conpanies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the asumption that our charges will be paid in full by an insurance company.

A service charge of a 1.5% per month (*18% per annum*) on the unpaid balance will be assessed on all accounts exceeding sixty (*60*) days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward, by the dentist, I agree to pay the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (*30*) days of billing if credit shall be extended, I further agree that the reasonable values of said services shall be as billed unless objected to by me, in constitute a waiver of any further term or condition, and I further agree that a waiver of any breach of any term 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 is instituted hereunder to collect monies owed by me, including interest charges, processing fees and commissions (up to 40% of principle) that may be assessed by any collection agency retained to pursue in this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or the other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. M. Sean Lorscheider.

I certify that I have answered all questions on this form accurately and I hereby agree to abide by the conditions outlined there in.

STEP 7 PLEASE SIGN AND DATE BELOW

Signature of Patient, Parent or Guardian *Date* *Relationship to Patient*

LONE PEAK **DENTAL**
M. Sean Lorscheider DMD

PATIENT'S NAME _____

Please complete the following Medical History Form

STEP 1 MEDICAL INFORMATION

Y N 1. Are you having any pain or discomfort at this time?
Y N 2. Do you have or have you ever had bleeding or sensitive gums?
Y N 3. Do you feel nervous about having dental treatment?
Y N 4. Have you been hospitalized during the past two years?
Y N 5. Have you been under the care of a medical doctor during the past two years?

Physician's Name: _____ Address: _____

Type of Practice: _____ Phone #: _____

Y N 6. Have you taken any medication or drugs during the past two years?
Y N 7. Are you now taking any medication, drugs or pills? If YES, please list: _____
Y N 8. Are you allergic or have you reacted adversely to any of the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Nitrous Oxide
- ☐ Tetracycline
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Local Anesthetics
- ☐ Sulfa Drugs
- ☐ Latex
- ☐ Ibuprofen
- ☐ Acetaminophen
- ☐ Barbituates
- ☐ Do you have any other allergies?

If YES, please list: _____

Y N 9. Check any of the following which you HAVE HAD OR HAVE at the present time:

- ☐ Heart Failure
- ☐ Heart Disease or Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Congenital Heart Lesions
- ☐ Scarlet Fever
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Artificial Joints (Hip, Knee)
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Cosmetic Surgery
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Cough
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Thyroid
- ☐ X-Ray or COBALT Treatment
- ☐ Chemotherapy (Cancer, Leukemia)
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Cortisone Medicine
- ☐ Glaucoma
- ☐ Pain in Jaw Joints
- ☐ Cold Sores
- ☐ AIDS or HIV
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Fever Blisters
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervousness
- ☐ Psychiatric Treatment
- ☐ Sickle Cell Disease
- ☐ Bruise Easily
- ☐ Venereal Disease
- ☐ Other

Y N 10: When you walk up stairs or take a walk, do you ever have to stop because of pain in the chest, shortness of breath or because you are very tired?

PLEASE CONTINUE ON BACK

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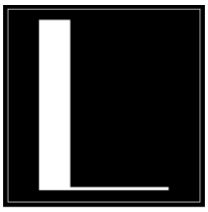

LONE PEAK **DENTAL**

CONSENT TO PROCEED

I authorize Dr. _____ and/or such associates or assistants as s/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 treatments.

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.

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____

LONE PEAK **DENTAL**

Effective Date:
February 17, 2018

Lone Peak Dental | 10060 N 4600 W Cedar Hills, UT 84062 | lonepeakdental@gmail.com | 801.492.0402

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests

- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We never market or sell personal information

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

By signing my name below, I certify that I have read and understand the above information. Any questions concerning this information have been discussed. A photocopy of this document is as valid as the original.

_____ _____

Patient (or Guardian) Signature **Date**