STONEHAVEN DENTAL

Patient name_____ Male Female
Date of birth_____Social security #_____-_____-_____ Married Single Child (under 14)
Address_____Apt #_____
City_____State_____ Zip_____
Telephone numbers: Home_____ Work_____ Cell Phone_____
Email Address_____ Best way to contact you_____
Legal guardian name (if Patient is under 18)_____

Nearest relative not living with you:
Name_____Address_____
City/State/Zip_____Phone#_____
How did you hear about our office?
Friend/Relative (name)_____

- ☐ Mailer
- ☐ Magazine/coupon
- ☐ Phone book
- ☐ Radio
- ☐ Insurance List
- ☐ Sign
- ☐ TV
- ☐ Web
- ☐ Other (please specify)_____

Please tell us what services you are interested in: (circle all that apply)

- Replacing Silver fillings
- Sedation/sleep Dentistry
- Smile Makeover
- Having a whiter smile
- Tooth replacement (implant/bridge)
- Braces/Invisalign

Please tell us of any other specific dental concerns you may have: _____
_____

CONSENT TO PROCEED: I authorize Stonehaven Dental Doctors or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative, 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 numbness, brusing and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, 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. Further, I understand that I am entering into a contractual relationship with the Stonehaven Dental Doctors for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare, and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me, I, the patient/guardian and or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Stonehaven Dental Doctors. Furthermore, should a meritorious medical/dental malpractice case or cause of action be initiated or pursed, I and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, Stonehaven Dental Doctors agree to the same stipulations.

_____ _____
Signature of patient, legal guardian or authorized agent Date

_____ _____
Witness Date

801-766-3600
StonehavenDental.com

STONEHAVEN Dental

General Dentistry, Oral Surgery,
Sedation & Orthodontics

FINANCIAL INFORMATION AND POLICIES

Person responsible for this account_____
Marital Status: Married Single
Address_____
Drivers License Number_____ Phone#_____

Is patient covered by dental insurance? Yes or No

Insurance Company Name_____
Address_____City/State/Zip_____
Telephone#_____
Whose name is the policy under? _____ Group#_____
Date of Birth_____ Social Security#_____-_____-_____
Employer Name_____ Employer Telephone#_____

Is patient covered by secondary insurance? Yes or No

Insurance company name_____
Address_____ City/State/Zip_____
Telephone#_____
Whose name is the policy under?_____ Group#_____
Date of Birth_____ Social Security#_____-_____-_____
Employer Name_____ Employer Telephone#_____

DENTAL INSURANCE is a contract between a patient /guardian and the insurance company and in no way absolves the patient/guardian of full responsibility for the charges incurred. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated. We are pleased to help process insurance forms, help maximize your insurance benefits and are glad to help answer any questions you may have about your treatment or treatment estimates.

SCHEDULED APPOINTMENTS: The time scheduled for your visit is set aside especially for you. We look forward to making your visit pleasant, comfortable and productive. In the unlikely event you are unable to make your appointment, we ask that you give us 24 hours notice so that we may give this time to other patients needing treatment. There will be a charge of $1.00/minute for appointment(s) missed or broken without 24 hours prior notice!

FINANCE CHARGES: A monthly charge of 1.5% (18% annually) will be added to all account balances not paid within 60 days of services. A late fee of $10/month will be assessed to all past due accounts.

I have read, understand and agree to the above policies. In the event of default, I agree to pay all cost of collection as well as court costs and reasonable attorney's fees in the event legal action is taken.

_____ _____
Signature of patient, legal guardian or authorized agent Date

_____ _____
Witness Date

181 N. 1200 E. Lehi, UT 84043 - 801.766.3600
www.MyUtahDENTIST.com

STONEHAVEN Dental

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MEDICAL HISTORY

Patient Name_____

Physician's Name_____ **Phone:**_____

Please answer the following questions as completely as possible (circle "YES" or "NO")

Do you consider yourself to be in good Health?	Y	N
Are you now or have you been under a physician's care within the past year?	Y	N
If yes, specify conditions being treated_____		
Do you take any medications, including birth control pills?	Y	N
Please specify name and purpose of medications:_____		
Do you have or have you ever had any heart or blood problems?	Y	N
Have you ever been told that you have a heart murmur?	Y	N
Do you require antibiotic premedication for a heart condition, artificial valve or artificial joint?	Y	N
Do you have or have you ever had high blood pressure?	Y	N
Do you bruise or bleed easily?	Y	N
Have you ever been diagnosed as being HIV positive or having AIDS?	Y	N
Have you ever has hepatitis or liver disease?	Y	N
Have you ever had (circle if yes): rheumatic fever; asthma; any blood disorder; diabetes; Rheumatism; arthritis; tuberculosis; venereal disease; heart attack; kidney disease;		
immune System disorders; Others (please specify) _____	Y	N
Are you subject to fainting?	Y	N
Have you ever had any severe reaction to dental treatment or local anesthetics?	Y	N
Are you allergic to any local anesthetic OR any antibiotics?	Y	N
Are you allergic to any metals?	Y	N
Do you have any other allergies? If yes, please describe:		
_____	Y	N
Have you ever has a nervous breakdown or undergone psychiatric treatment?	Y	N
Have you ever received counseling for excessive use of alcohol and/or prescription drugs?	Y	N
Are you now in pain?	Y	N
How long ago did you last see a dentist?		
Do you think that your teeth are affecting your general health in any way?	Y	N
Do you have or have you ever had bleeding or sensitive gums?	Y	N
Are your teeth sensitive to hot and cold?	Y	N
Are you pleased with the appearance of your teeth when you smile?	Y	N
Are you pleased with the color of your teeth?	Y	N
Are you nervous or apprehensive about having dental work done?	Y	N
WOMEN		
Are you pregnant?	Y	N
Trying to get pregnant?	Y	N
Are you nursing?	Y	N

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE OF MEDICAL CONDITION OF MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT VISIT.

_____ _____

(Patient, legal guardian or authorized agent) **Date**

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STONEHAVEN
Dental

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MUTUAL AGREEMENT TO MAINTAIN PRIVACY

The Dentists at Stonehaven Dental and the patient listed below agree to maintain Privacy of the patient as outlined in the HIPPAA form, The Dentists take pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, HIPAA forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Stonehaven Dental believes this is improper and may not be in the patients' best interest. Accordingly, the Dentists agree not to provide any list to an outside company for marketing anything other than our office or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly. Regardless of legal privacy loopholes, Stonehaven Dental will never attempt to leverage its relationship with patient by seeking patient's consent for marketing products for other companies.

In consideration for treatment and the above notes patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Stonehaven Dental or the dentists, expertise and/or treatment- the sole exceptions being communication to a confidential dental-peer review body: to another healthcare provider: to a licensed attorney: to a governmental agency: in the context of a legal proceeding: or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If Patient does prepare commentary for publication about Stonehaven Dental and/or our dentists or employees, the patient exclusively assigns all Intellectual Property rights, including copyrights, to Stonehaven Dental for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Stonehaven Dental. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Stonehaven Dental has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon Stonehaven Dental or its dentists: Patient will use all reasonable efforts to prevent any member of their immediate family or acquaintance from, engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage the practice.

Our Dentists feel strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Dentists and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via internet, blogs or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dentist's last date of service to the patient: or (b) three years beyond any termination of the dentist-patient relationship. As a matter of office policy, Dentists are requiring all patients in the practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all patients.

Patient and Dentists acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, patient and Dentists agree to the right of equitable relief (including but not limited to injuctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Patient or guardians Signature_____date_____

Witness Signature_____date_____

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