DR. ROBERT
FERRELL
DMD, MS

www.drrobertferrell.com

PATIENT INFORMATION

Name_____ Birthdate_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Emergency Contact _____ Phone_____

Relation _____

May we share/review your information with them? Yes or No

DENTAL INSURANCE INFORMATION

Name of Insured_____Relationship to Patient_____

Birthdate_____ Soc. Sec# or ID#_____

Name of Employer_____Work Phone_____

Insurance Company_____Group#_____

Ins.Address_____City_____State_____Zip_____

Ins. Phone#_____

Do you have dual coverage? No Yes If yes complete the following.

Name of Insured_____Relationship to Patient_____
Birthdate_____ Soc. Sec#_____or ID#_____
Name of Employer_____Work Phone_____
Insurance Company_____ Group#_____
Ins. Co. Address_____City_____State_____Zip_____
Ins. Phone#_____

General Dentist_____

Are there any family or friends whom we may thank for this referral?_____

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MEDICAL QUESTIONNAIRE

Patients Name_____Date_____
Your Physician's Name_____ Physicians Phone#_____
List of current medications you are taking _____ _____
_____
_____
Any current allergies? _____
Medication Allergies?_____

Do you need to premedicate due to a heart condition or artificial joints for dental treatment? Yes____No____
Have you received or are you currently taking medication known as bisphosphonates
(For example, Zometa, Aredial or Fosamax?) Yes___ No___

Any History of:			Medications for Problem
Heart Problems	Yes___ No___		_____
High Blood Pressure	Yes___ No___		_____
Heart Valve Problems	Yes___ No___		_____
Rheumatic Fever	Yes___ No___		_____
Kidney, Liver Disease	Yes___ No___		_____
Glaucoma	Yes___ No___		_____
Emotional Stress	Yes___ No___		_____
Prolonged Bleeding	Yes___ No___		_____
Asthma	Yes___ No___		_____
Epilepsy/Seizures	Yes___ No___		_____
Arthritis	Yes___ No___		_____
Hepatitis	Yes___ No___	A B C	_____
Diabetes	Yes___ No___	Type I Type II	_____
Artificial Joints	Yes___ No___	How long ago?	_____
HIV /AIDS	Yes___ No___		_____
Sinus Problems	Yes___ No___		_____
Osteoporosis	Yes___ No___		_____
Cancer	Yes___ No___	What type	_____
Pregnant	Yes___ No___	Due Date	_____
Sleep Apnea	Yes___ No___		
Tobacco Use	Yes___ No___	Smoke/Chew How Long_____Amount_____	

Complications/Allergy to Local Anesthetics, Nitrous Oxide, and/or IV Sedation_____

Other_____
_____

Signature_____Date_____

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OFFICE PRIVACY POLICIES

THIS NOTICE describes the privacy policies of this dental office. This office strives to maintain confidentiality as far as your dental treatment information. In this summary we describe how this confidential dental and health information is used and disclosed and how you can gain access to this confidential information.

BACKGROUND INFORMATION:

We are required by applicable law to maintain confidentiality of dental health information generated for patients during the course of treatment. We are required to notify all patients about our privacy practices and your right concerning your health information. These office privacy policies take effect as of April 14, 2003 and will remain in effect until amended by this office. We reserve the right to change the privacy practices of this office and the terms of this notice as any time, provided that such changes are permitted by applicable law, and we will make you aware of any changes we make. Our patients are welcome to request copies of our privacy policies at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION:

TREATMENT: We may use or disclose your dental health information to dental colleagues, your physician or other health care providers rendering treatment.
PAYMENT: We may use or disclose your dental treatment information through regular mail, fax or electronic transmission to your dental insurance carrier to obtain payment for services rendered. Limited treatment information may also be disclosed to billing services which assist the office preparing monthly billing statements.
DENTAL PRACTICE OPERATIONS: We may disclose your health information in conjunction with our health care operations.
YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment, or dental practice operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.
DISCLOSURE TO FAMILY AND FRIENDS: You have the right for us to disclose your own personal dental health information.
PERSONS INVOLVED IN CARE: We may use or disclose dental health information to identify or assist in the identification of you or a family member in conjunction with a forensic investigation.
MARKETING: We will not use your dental health information or images of your face and/or teeth for a marketing communications without your specific written authorization to do so.
SUBPOENA: We may use or disclose your health information when we are required to do so by law through subpoena.
ABUSE OR NEGLECT: We may disclose dental information of minor patients to appropriate authorities if we have reason to believe that they are possible victims of abuse, neglect or domestic violence or the possible victim of other crimes.

APPOINTMENT REMINDERS: We may use or disclose basic dental information insofar as the fact that you have a dental appointment scheduled in the form of appointment reminders such as voicemail messages, postcards, letters or e-mail messages.

PATIENT RIGHTS

ACCESS: You have the right to read over or obtain copies of your dental health information, with limited exceptions. Utah law (R-156-69-502(7) specifies that original records must remain in possession of the treating dentist for seven years, but you may request copies for a nominal fee.

QUESTIONS AND COMPLAINTS: If you want additional information about our privacy policies or have questions or concerns, you should contact our privacy officer. If you believe or are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your dental health information, you may complain to us by writing to our privacy officer. You also may correspond with the U.S. Department of Health and Human Services. We will provide you with the address of the U.S. Department of Health and Human Services upon request.

ACKNOWLEDGEMENT OF OFFICE PRIVACY POLICIES

I, _____ have read and agree to this office's Privacy Policies.

_____
Name (Please Print)

_____ _____
Signature Date