INFORMATION

PERSONAL

NAME (LAST, FIRST, MIDDLE INITIAL) | PREFERRED NAME

STREET ADDRESS | HOME PHONE #

CITY | STATE | ZIP CODE | MOBILE PHONE #

EMAIL ADDRESS | WORK PHONE #

MALE / FEMALE | BIRTHDATE | SOCIAL SECURITY #

WHO REFERRED YOU TO OUR OFFICE? | ☐ MARRIED ☐ SINGLE ☐ OTHER

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT THAN ABOVE (LAST, FIRST, MIDDLE INITIAL)

STREET ADDRESS | HOME PHONE #

CITY | WORK PHONE #

STATE | ZIP CODE | MOBILE PHONE #

RELATIONSHIP TO PATIENT | BIRTHDATE | SOCIAL SECURITY #

INSURANCE

PRIMARY

INSURANCE COMPANY | INSURANCE PHONE #

INSURANCE POLICY ID # | INSURANCE GROUP #

POLICY HOLDER NAME (LAST, FIRST, MIDDLE INITIAL) | POLIICY HOLDER PHONE #

RELATIONSHIP TO PATIENT | POLICY HOLDER BIRTH DATE | POLICY HOLDER SOCIAL SEC #

SECONDARY

INSURANCE COMPANY | INSURANCE PHONE #

INSURANCE POLICY ID # | INSURANCE GROUP #

POLICY HOLDER NAME (LAST, FIRST, MIDDLE INITIAL) | POLIICY HOLDER PHONE #

RELATIONSHIP TO PATIENT | POLICY HOLDER BIRTH DATE | POLICY HOLDER SOCIAL SEC #

OTHER

PERSONAL

SPOUSE NAME | SPOUSE PHONE #

EMERGENCY CONTACT | EMERGENCY CONTACT PHONE #

PHYSICIAN | PHYSICIAN PHONE #

FILL IN THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING

MEDICAL HISTORY

- ☐ ALLERGY: ANESTHETIC
- ☐ ALLERGY: CODEINE
- ☐ ALLERGY: LATEX
- ☐ ALLERGY: PENICILLIN
- ☐ ALLERGY: OTHER
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ CANCER
- ☐ DIABETES
- ☐ DEPRESSION
- ☐ DIZZINESS
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ HEAD INJURIES
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV / AIDS
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL DISORDERS
- ☐ NERVOUS DISORDERS
- ☐ PACEMAKER
- ☐ PREGNANT (CURRENT)
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ SURGERY
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ ULCERS

☐ YES HAS A DOCTOR INSTRUCTED YOU TO PRE-MEDICATE BEFORE ROUTINE DENTAL VISITS?

LIST ALL CURRENT MEDICATIONS

DENTAL HISTORY

- ☐ BLEEDING GUMS
- ☐ CURRENT TOOTH PAIN
- ☐ DIFFICULTY CHEWING
- ☐ FEAR OF THE DENTIST
- ☐ HALITOSIS (BAD BREATH)
- ☐ INJURY TO FACE, JAW, OR TEETH
- ☐ PERMANENT TEETH THAT ARE LOOSE
- ☐ ORAL SURGERY (EXTRACTIONS)
- ☐ ORTHODONTIC TREATMENT
- ☐ PERIODONTAL (GUM) SURGERY OR DISEASE
- ☐ POPPING OR LOCKING OF THE JAW
- ☐ SENSITIVE TEETH
- ☐ SINUS PRESSURE OR PAIN
- ☐ UNUSUAL REACTION TO ANESTHETIC
- ☐ OTHER SPECIFIC DENTAL PROBLEM

ANY OTHER HEALTH CONCERNS NOT LISTED ABOVE

ADDITIONAL DETAILS

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO CERTIFY THAT I AM IN GOOD HEALTH AND I AM ABLE TO UNDER GO DENTAL TREATMENT WITH LITTLE OR NO RISK. BY SIGNING THIS DOCUMENT, I AM FREELY GIVING MY CONSENT TO FOLLOW THE POLICIES AND PROCEDURES AS OUTLINED IN THE PRIVACY AND POLICY PACKET, AND ACCEPT MY RESPONSIBILITIES AS A PATIENT OR THE LEGAL, AUTHORIZED REPRESENTATIVE OF A PATIENT. I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS DOCUMENT, BUT BY DOING SO, I MAY BE DENIED SERVICE.

SIGNATURE OF PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE | REVIEWED BY - INITIAL | REVIEWED BY - DR. INITIAL | ☐ UPDATES ON BACK

PATIENT ACKNOWLEDGEMENT OF RECEIPT AND CONSENT

PRINTED NAME OF PATIENT

Welcome to Maughan Dentistry, the general dental practice of Dr. Kenneth Maughan and Dr. Michael Maughan. Our mission is to enhance each patient's life by offering a superior dental experience combining exceptional quality and convenience with individual attention and service. Initially, we will treat any existing dental problems, but our goal for your future will be prevention of tooth decay and gum disease. We will work together to improve your dental health, knowledge, and physical appearance.

We feel it is very important to provide you with the following full-page information sheets so that you may understand your rights and responsibilities as a patient. Please take some time to review them carefully, ask any questions, and resolve any concerns you may have before signing. We are so glad you have chosen our office and we look forward to serving you.

☑ **NOTICE OF PRIVACY PRACTICES (**FORM: K0003 2 Pages)

PATIENT INITIALS

Office policy and procedure designed to protect your personal health information in accordance with the HIPPA Privacy Act.

☑ **FINANCIAL POLICY** (FORM: K0001OFP)

PATIENT INITIALS

Office policy concerning fees, payment options, and patient's responsibilities regarding appointments, procedures, payments, insurance claims, and communication.

☑ **GENERAL INFORMED CONSENT** (FORM: K0002GIC)

PATIENT INITIALS

Acceptance of any and all possible risks associated with treatment provided by employees and/or agents of KCM Dental

☑ **DENTAL EMERGENCIES** (FORM: 0140EMR)

PATIENT INITIALS

Office policy and procedures related to emergency services, fees, and examples of dental emergency prevention and response.

By initialing, I acknowledge that I have received the separate, full-page informational sheets listed above.
I have been given the opportunity to read them and ask any questions regarding the nature and purpose of the policies and procedures. I have received answers to my satisfaction.

By signing this document, I am freely giving my consent to follow the policies and procedures as outlined and accept my responsibilities as a patient or the legal, authorized representative of a patient. I understand that I may refuse to sign this document, but by doing so, I may be denied service.

PRINTED NAME OF PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE

SIGNATURE OF PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

PRINTED NAME OF WITNESS

SIGNATURE OF WITNESS

DATE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information.

We must follow the privacy practices that are described in this Notice while it is in effect. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes effective for all health information that we maintain, including health information we created or received before the changes were made.

You may request a copy of this Notice or more information about our privacy practices at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for the following:

Treatment: Physicians or other healthcare provider providing treatment to you.

Payment: Collection agencies and Insurance Companies to obtain payment for services we provide to you.

Healthcare Operations: Staff Members and other professionals for quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Specified Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us specific written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but ONLY if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities it we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, mobile texts, postcards, or letters).

Marketing Health-Related Services: We will *not* use your health information for marketing communications without your written authorization.

Continued on back…

NOTICE OF PRIVACY PRACTICES

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in WRITING to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, a $20.00 administration fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 20, 2010. If you request this accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in WRITING. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in WRITING, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: AIMEE WIND

Telephone: 801-226-3302

E-mail: info@oremdmd.com

Address: 819 N. 900 W. OREM, UT 84057

PATIENT EDUCATION AND INFORMED CONSENT
OFFICE FINANCIAL POLICY

FINANCIAL POLICY

1. **Dental Insurance.** 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 companies and will credit any such collections received to the patient's account. However, it is the patient's responsibility to send any required preauthorization documentation and contact their insurance company to ensure that they are eligible for and have the benefits to cover the recommended treatment. If at any time a dental claim is denied and the entire balance due becomes the patient's responsibility.

2. **Dental Insurance Estimates.** We provide ESTIMATES for the insurance and patient's portion as a courtesy for our patients. However, our estimates may not take into account any deductibles, write offs, maximums, insurance exclusions, limitations, etc… In order for our patients to receive a more accurate estimate, we will provide a treatment plan of Dental codes and associated fees so the patient may contact the insurance company directly.

3. **Quoted Fees and Fee Increases.** Any fees quoted for recommended treatment are subject to change. Our standard fee schedule increase takes effect January 1st of each year and our preferred provider fee schedules change in accordance with dental insurance/plan carrier.

4. **Appointment Cancellations.** We value your time by reserving a specific room for you when you make your appointment. We do not overbook our schedule in exchange for your prompt arrival. If it becomes necessary to reschedule, 24-hour advance notice is required, otherwise, a $35.00 cancellation fee will be charged to your account.

5. **Payment Options.**
   - Cash: Cash will be accepted at the time of service. We will not accept responsibility for cash payments lost in the mail.
   - Personal Check: Personal checks will be accepted with the understanding that the account holder must agree to pay a $25.00 fine on each returned check.
   - Credit Cards: VISA and Master Card will be accepted and processed on the day of service.

6. **Financial Arrangements and Billing Statements.** As a condition of your treatment by this office, financial arrangements must be made in advance and in writing. No representative of the office is authorized to make a verbal financial arrangement. Billing Statements are sent out monthly. All "Balance Due" Amounts must be paid within fifteen (15) days of receiving your billing statement. Delinquent accounts will be charged interest at 11/2% per month. If at any time your balance goes past 120 days, and financial arrangements have not been made, your account will be turned over to a collection agency.

7. **Collections / Legal Action**. I agree to pay all collection costs (if my account is sent to a collection agency) and any attorney fees (if a suit is instituted hereunder) to collect monies owed by me. I further agree to pay additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

PATIENT COMMITMENT

1. **Charges and Payments.** I accept responsibility to verify the charges of any treatment before allowing Maughan Dentistry associates and agents to perform any such services. 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 at the time said services are rendered. I further agree to pay any reasonable additional fee(s) associated with a returned check or declined request for an electronic funds transfer.

2. **Communication**. I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning the balance due, appointments, and/or results on my answering machine or with a family member.

GENERAL INFORMED CONSENT

I UNDERSTAND that Dental Treatment includes possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of results or recovery have been made nor are implied:

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1. **Preventative and Basic Treatment:** I understand that cleanings, exams, full-mouth x-rays, and fluoride treatments are the standard procedures for preventative appointments. I understand that as part of dental treatment, including preventive procedures and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. 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.

2. **Local Anesthetic:** 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.

3. **Crowns, Bridges, Dentures, etc:** 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. Teeth may be sensitive and/or teeth may require subsequent root canal therapy.

4. **Root Canal Therapy:** I understand that as part of dental treatment, damage to fillings or porcelain crowns may occur no matter how carefully the related endodontic procedures are performed. Fractured fillings or crowns may require replacement at my expense.

5. **Additional Information is Available:** I understand that additional information is available upon my request. I understand that the procedure-specific informed consent outlines additional risks and my associated responsibilities.

6. **Fees for Services Performed:** I accept responsibility to verify the charges of any treatment before allowing Maughan Dentistry associates and agents to perform any such services. I also accept responsibility to send any required preauthorization documentation and/or contact my insurance company to ensure that I am eligible for the recommended treatment and/or verify their allowable fees. If at any time a dental claim is denied, I accept responsibility for the entire balance due.

7. **Acceptance of Risks:** I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general 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.

8. **Authorization:** I authorize Dr. Kenneth C. Maughan, Dr. Michael Maughan and/or his 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 preventative, restorative, palliative, therapeutic or surgical treatments.

PATIENT EDUCATION AND INFORMED CONSENT
DENTAL EMERGENCIES

If you have an emergency, please contact our office at **(801) 226-3302**. When our office is closed, our answering machine message will include an emergency contact number. If for any reason a situation may be life threatening, go to a hospital emergency room immediately.

Emergency Fees and Associated Charges. Out of respect for our other patients, who have previously scheduled their appointments, we try to only schedule emergencies during our lunch hour or at the end of the day. We will make every attempt to resolve your issues at this appointment, but it may be necessary to schedule another appointment to treat your problem. When you do come in with an emergency, please be aware that you will be charged for an exam, x-rays, emergency fee, and the standard charges of any treatment that is performed. Emergency fees are determined by the date of your last preventative appointment and the day of your emergency. *Example: Emergency fees* range from $0 (*a patient has had cleaning and exam, with our office, in the last 12 months, and needs to come in on a regular work day*) to $125 (*a new patient who needs to come in on a holiday*).

There are a number of simple precautions you can take to avoid a dental emergency. But, accidents do happen, and knowing what to do when one occurs can mean the difference between saving and losing a tooth.

AVOID EMERGENCIES BY:

9. **Preventative Maintenance**. Brushing and flossing twice a day, especially after eating sweet foods, can prevent the formation of cavities and gingivitis. It is important to have your teeth cleaned and examined once every six months and x-rays taken once every year. These routine appointments usually catch a problem before it turns into a root canal, broken tooth, or worse.

10. **Mouth guards and Bite guards**. Always wear a mouth guard when participating in sports or recreational activities that may pose a risk. Always wear a bite guard when you have a known habit of grinding your teeth or clenching your jaw.

11. **Activities to Avoid.** Do not chew ice, popcorn kernels, or hard candy, etc... all of which can fracture teeth. Do not use your teeth to open or rip packaging and other items. Do not chew sticky food when a temporary restoration has been placed in your mouth.

RESPOND TO EMERGENCIES BY:

1. **Cut Lip or Tongue.** Clean the area gently with a cloth and apply cold compresses to reduce any swelling. If the bleeding doesn't stop, go to a hospital emergency room immediately.

2. **Broken or Cracked Tooth.** Rinse your mouth with warm water to clean the area. Use cold compresses on the area to keep any swelling down. Call our office immediately.

3. **Broken Jaw.** If you believe your jaw could possibly be broken, apply cold compresses to control swelling. Go to a hospital emergency room immediately.

4. **Knocked Out or Loosened Tooth.** If the tooth has just been loosened, reposition the tooth, and call our office immediately. Otherwise, hold the tooth by the crown and rinse off the root of the tooth in water. Do not scrub it or remove any attached tissue fragments. If possible, gently insert and hold the tooth in its socket. If that isn't possible, wrap the tooth is gauze and put the tooth in a cup of cold milk and call our office immediately. Remember to bring the tooth with you!

5. **Temporary or Permanent Crowns and Bridges.** If you have a temporary or permanent crown or bridge that has fallen out, rinse your mouth with warm water to clean the area. Dry the area and place toothpaste or denture adhesive on the crown or bridge. Reposition it in your mouth to prevent the surrounding teeth from moving and contact our office.

6. **Objects Caught Between Teeth.** Try to gently remove the object with dental floss; avoid cutting the gums. Never use a sharp instrument to remove any object that is stuck between your teeth. If you can't dislodge the object using dental floss, contact our office.

7. **Toothache or Swelling.** Rinse your mouth with warm water to clean it out. Gently use dental floss to ensure that there is no food or other debris caught between the teeth. Never put aspirin or any other painkiller against the gums near the aching tooth because it may burn the gum tissue. If the pain persists, contact our office.