saluté DENTAL
family & cosmetic dentistry

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7325 Tamarack Road
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651.209.0270
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NEW PATIENT ANNOUNCEMENTS

important

FAILED APPOINTMENTS

The purpose of this letter is to share with you our concern regarding the biggest problem encountered by our dental practice. Although this letter may not pertain to you, we feel it is important to communicate this with all of our patients. Ultimately, the problem is "no shows" and the "last minute cancellation" of appointment times.

When a patient chooses to reserve time at our clinic, in return we agree to reserve staff and facility resources specifically for that patient. Our clinic thoughtfully recognizes that on occasion last minute illnesses and emergencies can arise. However, when a patient chooses to fail their reserved time, or reschedule without providing sufficient notice, the opportunity for our staff to provide vital dental care to others during that time is lost.

In an effort to eliminate future broken appointments, our clinic is providing this initial reminder to each of our patients and asking them to honor their commitment to keep their future appointments.

Without a doubt, you are valued and we would like to provide your dental services. As a courtesy, if you ever happen to have a scheduling conflict you must provide *at least a full 24 hours advance notice*. We will always be happy to reschedule a time more convenient to you.

INSURANCE BENEFITS/TREATMENT

If you have dental insurance, the coverage under your plan was independently determined by your employer and your insurance provider. Saluté Dental was not a party to the contract. As a result, your dental insurance plan has a wide variety of rules and exclusions governing reimbursement of the treatment you receive that Saluté Dental may not be aware of.

In order to understand what out-of-pocket expenses you may incur, if any, every patient is personally responsible for contacting their insurance provider and verifying plan coverage prior to treatment. Each patient is also responsible for forwarding their dental records from their previous dentist(s) to avoid the potential need for any duplicative services that may not be covered.

Treatments recommended and provided by Saluté Dental are solely based on established dental and medical guidelines which advance the best interest of each patient's own health. Saluté Dental does not change or impair it's diagnosis and/or treatments on the possibility that fees may not be paid by your dental insurance company.

Thank you for your understanding in these matters. If you have any questions please feel free to contact us.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations:

- ****Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would be crowns, fillings, teeth cleaning procedures, etc.
- ****Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities and utilization review. Examples of this would be billing your dental plan for your treatment completed and contacting your insurance carrier to check eligibility and benefit information.
- ****Health Care Operations** include the business aspects of running our practices. Such as, conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. For example, reviewing our documentation protocols periodically.

In addition, your confidential information may be used to remind you of an appointment, by phone or mail, or provide you with the information about treatment alternatives or other health-related services. Any other use or disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice listed below.

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- **The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- **The right to access, inspect and copy your protected health information.
- **The right to request an amendment to your protected health information.
- **The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health operations.
- **The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the revised notice from our practice.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Human Services, Office of Civil Rights, in the event you feel your rights have been violated. We will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services. You may contact us using the information listed above.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Privacy Practices.
(Please Print Patient Name)

_____
(Patient or Personal Representative Signature)

_____
(Date)

_____
(Description or Personal Representative's Authority)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify)

_____

_____

_____

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PATIENT INFORMATION

Please select one: ☐Dr. ☐Mr. ☐Mrs. ☐Ms.

Name: Last _____ First _____ MI_____

Address: _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

Birthdate: _____ S.S. #: _____ E-mail address: _____

Are You a Full Time Student? ☐Yes ☐No If Yes, Name of School: _____

How did you hear about our office? _____

RESPONSIBLE PARTY (PARENT/GUARDIAN) INFORMATION ***Please check here if same as above:*** ☐

Please select one: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. Relationship to Patient: _____

Name: Last _____ First _____ MI_____ Birthdate: _____

Address: _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

EMERGENCY CONTACT INFORMATION

Name of Nearest Relative Not Living with You: _____Phone: _____

INSURANCE INFORMATION

Please select one: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. Relationship to Patient: _____

Policyholder's Name: Last _____ First _____ MI_____

Birthdate: _____ S.S. #: _____ Employer: _____

Insurance Company Name / Claim Address: _____ Group Number: _____

SECONDARY INSURANCE:

Please select one: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. Relationship to Patient: _____

Policyholder: Last _____ First _____ MI_____

Birthdate: _____ S.S. #: _____ Employer: _____

Insurance Company Name / Claim Address: _____ Group Number: _____

CONSENT FOR SERVICES

I affirm that the information provided above and on the "Patient Health History" is correct and that it is my responsibility to promptly inform Saluté Dental of any changes. As a condition of receiving treatment, I have read and agree to the terms on the "New Patient Announcements" as well as the following:

TREATMENT - I hereby authorize the staff at Saluté Dental to perform any and all forms of diagnosis, x-rays, photographs, medication, treatment, and therapy that is recommended for proper dental care. I understand and accept that all dental procedures and the use of anesthetic agents carry a certain risk.
INSURANCE - I fully agree to assign all insurance benefits to Saluté Dental and be financially responsible for all dental services and materials not paid by my dental insurance within 60 days of treatment.
PAYMENT & SERVICE CHARGES - I understand that payment for any portion of services rendered that is not covered by my dental insurance is due the day of treatment unless a payment plan is arranged in writing prior to treatment. I agree to pay a service charge of 1.5% per month (18% per annum) on all unpaid accounts exceeding 60 days. In the case of my default on payment of this account, I further agree to pay all collection costs and reasonable attorneys fees incurred in attempting to collect on any future outstanding account balances.

Signature (Patient, Parent or Guardian): _____ Date: _____

PATIENT HEALTH HISTORY

DENTAL HISTORY

Patient Name _____ Date of Birth _____

Former Dentist _____ Address/Phone Number _____

When was your last dental visit? _____ What was done at that visit?_____

Date last time x-rays were taken? _____

What is the current condition of your mouth? ☐ Good ☐ Fair ☐ Poor

How often do you brush your teeth per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more ~ Electric toothbrush? ☐ Yes ☐ No

How often do you floss your teeth per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

Do you have any of the dental concerns listed below?

Gum Disease	☐ Yes	☐ No	Crooked/Crowded Teeth	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	TMJ/clicking/popping in your jaw	☐ Yes	☐ No
Gum Sensitivity	☐ Yes	☐ No	Breathe Malodor	☐ Yes	☐ No
Food catches between teeth	☐ Yes	☐ No	Snoring/Sleep Apnea	☐ Yes	☐ No
Tooth Sensitivity	☐ Yes	☐ No	Untreated problems	☐ Yes	☐ No
Loose Teeth	☐ Yes	☐ No			
Grinding or clenching your teeth	☐ Yes	☐ No	Other (*please explain*): _____		

Any Previous Bad Dental Experiences or Fears (*please explain*): _____

COSMETIC ASSESSMENT

Would you like your smile to look better or different?	☐ Yes	☐ No
Do you have discolored teeth that bother you?	☐ Yes	☐ No
Would you like whiter teeth?	☐ Yes	☐ No
Would you like a free shade/color evaluation?	☐ Yes	☐ No
Have you ever had your teeth bleached?	☐ Yes	☐ No
Have you ever worn braces on your teeth?	☐ Yes	☐ No

MEDICAL HISTORY

Are you under the care of a medical professional? ☐ Yes ☐ No Date of Last physical: _____

Physician name: _____ Phone: _____ Clinic: _____

Are you currently taking any medications, recreational drugs or herbal supplements? ☐ Yes ☐ No

(*please list, if any*) _____

Have you been told by a health professional to take antibiotics before dental procedures? ☐ Yes ☐ No

Do you have any drug allergies or sensitivities?

Penicillin	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Local Anesthetic	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No
Nitrous Oxide	☐ Yes	☐ No	Other	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	(*please list*): _____		

Do you have allergies to any foods or materials? ☐ Yes ☐ No (*please list, if any*) _____

Do you currently have, or have you ever had any of the following?

Heart Problems/Surgery	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Defects	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Abnormal Blood Pressure	☐ Yes	☐ No	Prosthetic Implant	☐ Yes	☐ No
Blood Disorders	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Currently Pregnant	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Tobacco Use	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Lung Disease(s)	☐ Yes	☐ No	Used Fen-Phen or Redux	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No			

Any other past/present health problems, hospitalizations or illnesses not listed? ☐ Yes ☐ No

Please explain any answered "yes" above: _____

_____

The above information is true and correct. I have answered every question on this form completely. I understand that the health information I provided will be used by Saluté Dental to assist in determining appropriate dental treatment. I will inform Saluté Dental of any change(s) in my health and/or medications prior to receiving further dental advice or treatment.

Signature: _____ Date: _____ Witness: _____