FEATHERSTONE RIDGE DENTAL CLINIC
REQUEST FOR OUTPATIENT DENTAL SERVICES

SERVICE REQUEST FOR:

Name:	Date of Birth:
Social Security #:	Telephone:
Address:	
Has the above individual been determined eligible for services from the Division of Services for People with Disabilities? Yes ☐ No ☐	
Type of service:	
Who is your Service Provider:	

PERSON REQUESTING SERVICES IF OTHER THAN ABOVE:

Name:	Title:
Address:	Telephone:
Relationship to patient (DSPD regional staff, QIDP, other):	
When is the best time to contact you?	
Additional contact (Support Coordinator, QIDP, etc.):	
Telephone:	
Legal Guardian:	
Address:	Telephone:

INSURANCE INFORMATION:

Name of Insurance Company(ies):	
ID#:	
Policy Holder:	
Medicaid #:	Medicare #:
Who will pay for services not covered by insurance?	
Billing Address:	Telephone:

MEDICAL HISTORY INFORMATION:

Primary Physician:	Telephone:
Primary Dentist:	Telephone:
What type of anesthesia has been used for previous dental appointments (nitrous oxide, general anesthesia, local anesthesia, etc.)?	
Is the above individual currently in dental pain? Yes ☐ No ☐	
Please list chief dental complaint:	
When was your last dental visit (include date, provider and provider phone number):	

HOW DID YOU LEARN ABOUT FEATHERSTONE RIDGE DENTAL CLINIC?

☐ Other Dentist or Doctor ☐ Word of Mouth/Friend ☐ Website/Online ☐ From My Provider

MEDICAL HISTORY FORM

MEDICAL AND DENTAL RECORDS MUST ACCOMPANY THIS FORM

For your safety please answer all questions carefully and honestly

	Yes	No
1. Have you ever been a patient at USDC?		
2. Are you taking or have you ever taken blood thinners, Coumadin, prednisone, heart pills, steroids, nerve pills, blood pressure pills, Fen Phen (diet pills) or Insulin? (circle which)		
3. Do you use herbal or food supplements? If yes, please list		
4. List any medications you are now taking or have taken in the past four months (Females – Are you taking a birth control pill? There is a higher incidence of "Dry Socket" with that medication. Also, if antibiotics are prescribed, the effectiveness of a birth control pill may be reduced and a pregnancy may occur) :		
5. Are you allergic to, or have had an unfavorable reaction to any medication?		
6. Do you itch, wheeze or get a rash from latex or a rubber product?		
7. Have you had an unfavorable reaction to local (numbing) or general (asleep) anesthetics?		
8. Do you use recreational drugs – i.e. : L.S.D., "Speed", "Downers", Mescaline, Cocaine, others?		
9. Have you ever been hospitalized or operated on? List year and reason:		
10. Have you had an unfavorable reaction from previous dental treatment?		
11. Do you get infections, sores, boils, sore throat or respiratory problems easily?		
12. Have you ever had Radiation Therapy for tumors?		
13. Have you or any family member had problems breathing following an anesthetic?		
14. Have you had recent weight changes or history of fever or chills and excessive sweating?		
15. What is your current Height? Weight?		
16. Do you get frequent headaches?		
17. Do you wear glasses, contact lenses, see double, or have glaucoma? (circle which)		
18. Do you have/had hearing difficulties, ringing in your ears, dizziness, earaches, drainage from ears, sinusitis, frequent nose bleeds, difficulty breathing through your nose? (circle which)		
19. Do you have/had breathing problems such as asthma, wheezing, T.B., chronic cough, coughed up blood, coughing spells, excessive sweating, emphysema? (circle which)		
20. Do you smoke? Packs per day? Use Alcohol?		
21. Do you have/had heart trouble, angina, chest pain, shortness of breath while laying flat or while climbing stairs; irregular pulse, palpitation, high blood pressure, heart murmur, rheumatic fever, dizziness, or fainting when getting up suddenly, ankle swelling, stroke? (circle one)		
22. Do you have/had stomach or liver problems, ulcer, vomited blood, colitis, yellow jaundice, hepatitis, frequent constipation? (circle which)		
23. Do you have/had kidney problems, frequent urination, frequent night time urination, nephritis, difficulty urinating, burning, blood in urine? (circle which)		
24. (Women) – Are you pregnant? Month?		
Number of past pregnancies: Are you nursing at present?		
25. Do you have/had thyroid trouble, fast heart rate, hot or cold intolerance? (circle which)		
26. Do you have diabetes, hypo-glycaemia, chronic thirst? (circle which)		
27. Do you have/had rheumatoid arthritis, broken bones, muscular dystrophy, polio (circle which)		
28. Does/has your jaw popped, clicked, cracked or locked open or shut (circle which)		
29. Have you been diagnosed with HIV, AIDS or ARC (auto-immune disorders)?		
30. Do you have/had anemia, bleeding problems, bruise easily, hemophilia? (circle which)		
31. Do you have/had fainting spells, convulsions, epilepsy, use Dilantin, subject to nervous disorder?		
32. Do you have Anorexia or Bulimia?		

Please check the boxes below:

- ☐ I have reviewed the above, and it is current and accurate.
- ☐ I have attached complete medical and dental historical records

Signature _____ Date _____

Patient, Parent, Guardian (circle)

ACKNOWLEDGEMENT OF RECEIPT
"NOTICE OF PRIVACY PRACTICES"

FEATHERSTONE RIDGE DENTAL CLINIC
MRAU OF UTAH

Individual's Name: _____

To be completed by Individual or the Individual's Personal Representative:
I hereby acknowledge receipt of the Featherstone Ridge Dental Clinic's "Notice of Privacy Practices" as required by law.

Individual / Personal Representative Name: _____
(Please Print)

Signature of Individual /
Personal Representative: _____ _____
(Signature) (Date)

Featherstone Dental Clinic

~ This notice is effective April 14, 2003 ~ amended September 12, 2013

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

YOUR HEALTH CARE INFORMATION IS PRIVATE

DHS complies with Federal law which requires us to keep your "protected health information" (PHI) private. Protected health information is information that relates to your physical or mental health and which identifies you, such as the health care we provide to you, your medical condition, your genetic information or payment for your health care. You have the right to be notified if your protected health information has been breached.

NOTICE

You have a right to know how we use and disclose your protected health information. We will use and disclose your protected health information only in the manner described in this notice.

OUR PRIVACY PRACTICES MAY CHANGE

We reserve the right to change our privacy practices and to make the changes apply for all health information that we have about you. If changes are made, a revised notice will be posted and copies will be available to you upon request. You may get a copy of the current notice from Featherstone Ridge Dental Clinic, 895 N. 900 W., American Fork, Utah 84003, (801)763-4164.

WHO CAN USE OR SEE YOUR HEALTH CARE INFORMATION?

We use your health information to provide you with treatment. For example, doctors, nurses, dentists and other health care providers may share information about you in order to provide you with the best possible treatment. The law also allows us to share your health information with insurance companies and others in order to obtain authorization, payment, or to pay for your health care. For example, bills for payment will identify you and may include your diagnosis, doctor's name, or the services you received. We also use protected dental/health information for our business activities or "dental care operations", such as conducting quality assessments, evaluations, and our management and administrative activities. We may contact you to remind you of appointments or to provide you with other information. The law does not require us to obtain your permission to use or disclose your protected health information for treatment, payment, or operations.

SOME DISCLOSURES ARE PERMITTED BY LAW

We may disclose some of your protected dental/health information to our contractors but only after they sign an agreement that requires them to ensure the privacy of your protected dental/health information. For example, we may disclose your protected dental/health information to prevent or lessen a serious threat to health or safety; to prevent the spread of communicable diseases; to monitor drugs or illnesses; to health oversight agencies who are conducting audits, inspections, or investigations such as investigating insurance fraud; to coroners or medical examiners; to research organizations; and for certain government functions such as military and national security activities.

SOME DISCLOSURES ARE REQUIRED BY LAW

We will disclose your protected dental/health information without your permission when Utah or Federal law requires us to do so. For example, some injuries must be reported to the police, and disclosures must be made to organ transplant organizations. Suspected cases of abuse, neglect or domestic violence must also be reported. We will disclose your protected health information when required by a valid court order or subpoena.

YOUR RIGHT TO LIMIT THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

You may ask us to restrict the use or disclosure of your protected dental/health information for treatment, payment or operations. We will consider your request, but are not required to agree to your request. We will comply with your request to not disclose your protected dental/health information to your health plan if you have notified us in advance that you, not your health plan, are going to pay for the services that we provide. If we do agree to your request, then we will honor it unless disclosure of your protected health information is necessary to provide you with emergency treatment. You may cancel a restriction at any time. We may also cancel a restriction at any time. If we cancel a restriction, we will notify you and we will continue to apply the restriction to information collected before the cancellation.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You may provide us with a specific telephone number or address to use to communicate with you privately.

YOUR RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION

You may see and get a copy of your protected dental/health information, including dental/medical and billing records. If you request an electronic copy of your protected dental/health information we will provide you with access in the electronic format requested if it is readily producible in that format. You must request this information in writing to Featherstone Ridge Dental Clinic. You will receive a response from us within 30 days. Under limited circumstances, we may deny you access to a portion of your dental/health information and give you a written explanation of our reasons. You may request a review of the denial in writing. We may charge you a fee for the cost of copies, summaries of your protected health information, or postage.

YOUR RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION

You may request that we amend your protected dental/health information. You must make your request in writing to Featherstone Ridge Dental Clinic and provide a reason for your request. If we deny your request, we will give you a written explanation of our reasons within 60 days. You may then submit a written statement disagreeing with our denial. Your statement may not be longer than 4 pages. You may file a complaint, as described at the end of this notice. Your amendments or statements may be shared when your protected dental/health information is disclosed or at your request.

YOUR RIGHT TO KNOW WHAT DISCLOSURES WE HAVE MADE

You may request a detailed list of our disclosures of your protected dental/health information. Your written request must state the period of time you want included, which must be within the 6 years immediately prior to your request. We are not required to include all disclosures. For example, disclosures to you or for treatment, payment or operations need not be included in the list of disclosures. We will respond within 60 days of receiving your request. Your first request in any 12 month period will be provided free of charge, but additional requests in any 12 month period may result in a fee.

YOUR PERMISSION IS REQUIRED FOR SOME DISCLOSURES

Your written permission is required before we can use or disclose your protected dental/health information for any reason not otherwise described in this Notice, such as marketing or disclosures to specific people or groups of people. Your written permission is required before we disclose substance abuse treatment records, or psychotherapy notes. Featherstone Ridge Dental Clinic does not participate in any marketing or fundraising activities and will not sell your protected health information. You may ask to have your protected health information provided to people that you identify. Your permission is given on an authorization form, which you may obtain through Featherstone Ridge Dental Clinic. You may revoke your permission for us to disclose your protected health information at any time, in writing.

WHAT PROTECTED HEALTH INFORMATION WILL MY FAMILY BE TOLD?

We may disclose protected dental/health information to your family, close friends, or people you identify as being involved in your care if the information is relevant to your care or payment for your care. We may release information about your location or death. You may ask us not to release this information, and we will honor your request unless disclosure of your protected dental/ health information is necessary to provide you with emergency treatment.

WHAT WILL MY VISITORS BE TOLD?

We maintain a directory of individuals who have been seen at Featherstone Ridge Dental Clinic. This directory may include your name, location, and phone number. We may disclose your name and condition to visitors who ask for you by name. If you ask us to restrict these disclosures, we will honor your request.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED

If you file a complaint, we investigate the incident, and we will not retaliate against you. If you believe we have violated your privacy rights, you may file a complaint with Featherstone Ridge Dental Clinic or with the U.S. Department of Health and Human Services, 999 18th Street Suite 417 Denver, CO 80202
Voice Phone: (800) 368-1019, Fax: (303) 844-2025, TDD: (800) 537-7697, e-mail: OCRComplaint@hhs.gov.