PATIENT REGISTRATION FORM

TAWZER DENTAL

First Name: _____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State/Zip: _____

Who can we thank for your referral? (Check any that apply)

☐ Insurance Provider List ☐ Online Search ☐ Location ☐ Current Patient _____ ☐ Other _____

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Occupation: _____ Employer _____

Sex: ☐ Male ☐ Female Birth Date: _____ Age: _____

Social Security Number: _____ Email: _____

If married: Spouse name: _____ DOB: _____ SSN: _____ Employer _____

Emergency Contact: _____ Relation: _____ Phone: _____

_____ (please initial): I authorize the use of my mobile phone (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

RESPONSIBLE PARTY (If patient above is a Child or Spouse, Please fill out info below)

First Name: _____ Last Name: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: ( )_____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Sex: ☐ Male ☐ Female Birth Date: _____ Age: _____ Marital Status: _____

Social Security Number: _____ Employer: _____ Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Address: _____

Employer: _____

Name of Insured: _____

DOB of Insured: _____

Relationship to patient: _____

Subscriber ID # (can be SSN) : _____

Group # _____

Secondary Insurance: _____

Address: _____

Employer: _____

Name of Insured: _____

DOB of Insured: _____

Relationship to patient: _____

Subscriber ID # (can be SSN) : _____

Group # _____

AUTHORIZATION

I authorize my insurance company to pay to Jarron Tawzer all insurance benefits otherwise payable to me for series rendered. I authorize the use of this signature on all insurance submission. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that Jarron Tawzer cannot render services on the assumption that any of the charges will be paid by an insurance company. I understand that I am financially responsible for all charges whether paid by my insurance or not. I understand that if I do not pay my bill collection action will be taken and I will be responsible for paying any collection and attorney fees.

Signature: _____ Date: _____

JARRON T. TAWZER D.M.D.

150 East 200 North, Ste. F Logan, UT 84321 Tel: 1.435.753.1686 Fax: 1.435.750.6736

MEDICAL HISTORY

TAWZER DENTAL

PATIENT _____ BIRTHDATE _____ GENDER _____ AGE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

	YES	NO	IF YES, PLEASE EXPLAIN
Are you currently under a physician's care?	☐	☐	Condition:
Have you ever been hospitalized or had a major operation?	☐	☐	
Have you ever had a serious head or neck injury?	☐	☐	
Do you take, or have you taken, Phen Fen or Redux?	☐	☐	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐	If yes, When?
Are you on a diet or special diet?	☐	☐	
Do you use tobacco?	☐	☐	If yes. amount per day:
Do you use controlled substances?	☐	☐	
Are you currently taking any med's, OTC pills, diet pills, or drugs?	☐	☐	If yes, Please list:
Have you ever been advised to pre-med for dental procedures?	☐	☐	If yes, Medication:

☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Metal ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other Allergies _____ Are you subject to Anaphylaxis? ☐ YES ☐ NO

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores
- ☐ Fever Blisters
- ☐ Congenital Heart
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Headaches/Migraines
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mental Disorder
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness, disorder, or condition not listed above? ☐ YES ☐ NO If yes, please explain: _____

_____

Additional Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ DATE _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

(Parent/Guardian must sign for patient 17 years old and younger)

FINANCIAL POLICY

TAWZER DENTAL

We request that our charges for office visits be paid at the time of service UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE MANAGER. A monthly statement will be sent on your account. A payment must be made by the 20th of every month on your outstanding balance. Failure to pay your account within the specified terms may result in phone calls and letters reminding you of your financial obligation, as well as the collection process.

INSURANCE

You are ultimately responsible for your entire balance. Any quotes given to you in regards to what your insurance may pay is solely an estimate and not a guarantee that insurance will pay. As a convenience, we will be happy to process your dental insurance claims for you. We ask that you provide us with current and accurate information regarding your insurance coverage. If insurance is not paid timely, the balance will be your responsibility.

METHOD OF PAYMENT

We accept cash, checks, Visa, MasterCard, American Express, and Discover Payments.

COLLECTIONS

Any account which fails to make payments in a timely and efficient manner, or fail to make any payments under the specified terms of this contract, may be turned over to a collection agency for legal processing. In that event, you will be assessed a collection fee of up to 40% of any remaining principal balance that may be turned over to the collection agency. Unpaid balances over 60 days old will be subject to a monthly billing charge of $25. Any payment received will be applied to billing charges first and account balances second until account balance is paid in full.

AUTHORIZATION, ASSIGNMENT AND GUARANTEE OF PAYMENTS

I hereby consent to any medical treatment rendered to me and guarantee payment of charges incurred on my behalf. I hereby assign and authorize payment of insurance benefits directly to Dr. Jarron Tawzer. Payments will not be delayed or withheld because of any pending insurance coverage. Any amount that is not covered by insurance carrier and all proceeds of insurance are assigned to Dr. Jarron Tawzer where applicable, but without Dr. Jarron Tawzer assuming responsibility for the collection of those claims.

In the event payment under this agreement is not made at the time and in the manner required, the undersigned agrees to pay all costs of collection, including attorney fees, court costs, filing fee, including charges of commissions, (not to exceed 40%), that may be assessed to us by a collection agency retained to pursue this matter, with or without suit. I also hereby agree to pay a finance charge of 11/2 % per month (18% per annum) on the unpaid balance after 30 days.

I am responsible for the following individuals _____

_____

Responsible Party Signature: _____ Date: _____

Print Name: _____

JARRON T. TAWZER D.M.D.

150 East 200 North, Ste. F Logan, UT 84321 Tel: 1.435.753.1686 Fax: 1.435.750.6736

HIPAA PRIVACY POLICY

TAWZER DENTAL

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 carefully. The privacy of your health information is important to us.

NOTICE OF PRIVACY PRACTICES

We are required by 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. This Notice takes effect August 1, 2016, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. A copy of the current noitice is avial-able upon request. The effective date of the Notice is provided above.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to another dentist or health care provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend, or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state workers' compensation laws.

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

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations, if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us 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 uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request to us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: 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, and health care operations, and certain other activities for the last six years, but not before August 1, 2016. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 550 W 465 N Suite #501, Providence, UT 84332.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 550 W 465 N Suite #501, Providence, UT 84332. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment). Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 550 W 465 N Suite #501, Providence, UT 84332.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 550 W 465 N Suite #501, Providence, UT 84332. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, 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, 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 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.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
550 W 465 N, Suite #501
Providence, UT 84332
Telephone: 435-753-1686

ACKNOWLEDGMENT OF RECEIPT

TAWZER DENTAL

I acknowledge that I received a copy of Jarron T. Tawzer D.M.D. Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date _____

JARRON T. TAWZER D.M.D.
150 East 200 North, Ste. F Logan, UT 84321 Tel: 1.435.753.1686 Fax: 1.435.750.6736

CONSENT TO PROCEED

TAWZER DENTAL

I authorize Jarron Tawzer D.M.D. and/or such 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 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, 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. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. 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. In some cases, sutures or additional treatment may be required.

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. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

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.

Patient Name: _____

Signature: _____ Date: _____

(Patient, Legal Guardian or Authorized Agent of Patient)

Witness: _____ Date: _____

JARRON T. TAWZER D.M.D.

150 East 200 North, Ste. F Logan, UT 84321 Tel: 1.435.753.1686 Fax: 1.435.750.6736