FAMILY SURGICAL SUITE
WELCOME!

Patient Information

Name _____ Date _____
Last First Middle

Address _____
Street Apt # City State Zip

Birth Date _____ Telephone _____
Mo Day Yr Home Cell Other

Name of Dentist Rendering Services at Family Surgical Suite Today: _____

Person Responsible for Account (Please check one) □ Patient □ Guardian □ Father □ Mother

Name _____ SSN _____

Emergency/Alternate Contact _____
Name Relationship Telephone

Responsible Party Information

_____
Last First M.I.

_____
Address City Zip

_____
Phone Cell

_____
Birth date (M/D/Y) SSN#

_____
Employer

_____
Dental Ins Subscriber# Grp#

_____
Medical Ins Subscriber# Grp#

Dental History

Primary Dentist _____

Date of last dental visit _____ For what service? _____

Any injuries to mount, teeth or head? □ YES □ NO
Any unhappy dental experiences? □ YES □ NO
Any mouth habits – thumb sucking, nail biting, mouth breathing, etc?
_____

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WELCOME!

Medical History

Is the patient under the care of a physician now? □ YES □ NO

If yes, Dr. Name and Telephone _____

Receiving any medications or drugs?	□ YES	□ NO	Medications
Ever been hospitalized?	□ YES	□ NO	
Ever had surgery?	□ YES	□ NO	
Is there excessive bleeding?	□ YES	□ NO	
Does the patient have allergies?	□ YES	□ NO	Allergies

Has the patient had any history or difficulty with any of the following?

If so please circle. If none, please check □ NO PROBLEMS

ADHD	Cancer	Epilepsy	Liver Disease	Thyroid Disease
AIDS/HIV	Cerebral Palsy	Fainting	Measles	Tonsillitis
Anemia	Chicken Pox	Hearing	Mononucleosis	Other
Asthma	Convulsions	Heart	Mumps	
Bladder	Diabetes	Hepatitis	Rheumatic Fever	
Breathing	Drug/alcohol abuse	Kidney Disease	Sinus	

All information on this page, the dental/medical histories and other information about today's treatment is correct to the best of my knowledge

Signature of Responsible Party Printed Name Date SSN#

Family Surgical Suite does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities or in employment.

PATIENTS BILL OF RIGHTS

INFORMATION DISCLOSURE
The patient has the right to receive accurate and understandable information, prior to and at the time of service, to make informed decisions, with assistance if necessary, regarding health plans, professionals and facilities.

PARTICIPATION IN TREATMENT DECISIONS:
The patient has the right to be fully informed prior to admission, of the treatment to be received, potential complications, and outcome. This right includes refusal of treatment and information of the medical consequences of such refusal. This right also includes: right of decision to participate or refuse to participate in experimental research.

ACCESS TO EMERGENCY SERVICES:
The patient has the right and responsibility to expect access to emergency health care services when and where the need arises.

CONFIDENTIALITY OF HEALTH INFORMATION:
The patient has the right to confidential treatment of personal and medical records and to approve or refuse release to any individual outside of the facility, except in the case of transfer to another facility or as required by law or third party payment entities.

RESPECT AND NONDISCRIMINATION:
The patient has the right to be treated with consideration, respect, and full personal dignity, including privacy and care of personal needs.

COMPLAINTS AND APPEALS:
The patient holds the right to a fair and efficient process for resolving differences with health care entities including an identified sequence for review and resolve.

PATIENT RESPONSIBILITIES:
It is reasonable to expect and encourage patients to assume reasonable responsibilities since patient involvement in their care increases the likelihood of achieving the best outcome and helps support quality improvement for patient care at Family Surgical Suite.

ADVANCE DIRECTIVES:
Family Surgical Suite does not honor patient advance directives.**Information available on request*

FOR CONCERNS PLEASE CALL:

Tyler DeHart, Surgical Center Manager - 801-833-0515
Utah State Health Department - 1-800-662-4157
Utah State Ombudsman - 801-538-4589

FAMILY SURGICAL SUITE PRIVACY PRACTICES

This notice describes how health information about you, as a patient of this practice, may be used and disclosed and how you can get access to your individually identifiable health information.

Our Commitment To Your Privacy:

Family Surgical Suite is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

We may use and disclose your PHI in the following ways:

Treatment

Family Surgical Suite may use your PHI to treat you. Many of the people who work for our practice, including but not limited to, our doctors and nurses may use or disclose your PHI to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to other health care providers for purposes related to your treatment.

Payment

Our practice may use and disclose your PHI to bill and collect payment for the services and items you may receive from us.

Operations

Family Surgical Suite may use and disclose your PHI for operations, which may include the evaluation of the quality of care you received from us, cost-management analysis, or business planning activities.

Use or Disclosure with Your Authorization

Your consent only permits us to use PHI for the purposes of treatment, payment, and health care operations. We may use or disclose your PHI for reasons other than treatment, payment, and operations when you give us written authorization on an approved form or there is an exception as noted in the following section.

Use or Disclosure without Your Authorization

Family Surgical Suite may use or disclose PHI for purposes of treatment, obtaining payment, and operations without your consent or your authorization when you require emergency care or when we try to obtain consent but are unable to due to a barrier of communication.

FAMILY SURGICAL SUITE PRIVACY PRACTICES

Public Health Functions

Family Surgical Suite may disclose your PHI for the purpose of (1) maintaining vital records (2) reporting child abuse or neglect (3) preventing or control disease, injury, or disability (4) notifying persons regarding potential exposure to a communicable disease or potential risks for spreading or contracting a disease (5) reporting or notifying of drug reactions or recalls (6) reporting potential abuse or neglect of an adult patient (7) notifying your employer under limited circumstances related primarily to workplace injury or illness.

Other Areas of Potential Disclosures

Family Surgical Suite may disclose PHI during a judicial proceeding in response to a lawsuit or similar proceeding. We may disclose PHI to law enforcement as required in relation to a crime, a death resulting from criminal conduct, criminal conduct at our offices, in response to a warrant or similar legal process, to identify a suspect or missing person, or in an emergency to report a crime.

Your Rights

If you would like more information about your privacy rights, are concerned we violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact Family Surgical Suite administration at (801) 495-1064.

Confidential Communications

Family Surgical Suite will honor reasonable written requests from you to receive PHI by alternative means of communication or at alternative locations.

Access to your Records

You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. Under limited circumstances we may deny you access to a portion of your records. If you request a copy or copies of your record, you may incur a fee.

Amending Your Record

You may ask us to amend your health information if you believe it is incorrect or incomplete. To request an amendment your request must be made in writing.

Notice, Questions, or Complaints

This notice describes the Family Surgical Suite privacy policies in accordance with the Health Insurance Portability and Accountability Act 1996, a federal law which specifies certain protections of your PHI. If a patient would like to file a complaint related to this policy you may contact: Administrator, Family Surgical Suite, PO BOX 2265 Sandy, Utah 84091.

Right to Change

Family Surgical Suite may change the terms of this Notice at any time. If a change is made we may make the new notice terms effective for all PHI that we maintain including any information created or received prior to issuing the new notice.

FAMILY SURGICAL SUITE POLICIES AND AUTHORIZATIONS

Patient Name: _____ Date of Birth: _____

POLICIES

I have received, read and understand my rights as a patient as outlined in the Patient Bill of Rights of Family Surgical Suite. Initial: _____

Family Surgical Suite will not honor advance directives. *(detailed information available on request)* Initial: _____

For the safety of the patient, I understand that a responsible adult must stay in the center during the surgery. I agree not to eat or drink in the facility out of respect for other patients who are fasting. Initial: _____

The smoking of cigarettes or the use of tobacco products shortly before a surgical procedure can have a detrimental effect on both the surgical outcome and the anesthetic care of the patient. For that reason, Family Surgical Suite has a standing policy that patients and the responsible attendees are not allowed to use tobacco products either inside or outside the facility from the time the patient is admitted until the time of discharge from the facility Initial: _____

AUTHORIZATIONS

I hereby authorize Family Surgical Suite and all dental/medical personnel within the facility to administer such medications and perform such diagnostic, photographic and dental restorations as may be necessary for proper care. Initial: _____

I have been informed of Family Surgical Suite's policy on privacy and have received a copy. I grant the right to Family Surgical Suite to release all information about my treatment to third party payers and/or other Healthcare Professionals Initial: _____

I hereby authorize payment to Family Surgical Suite. I understand I am responsible for any charges of facility and anesthesia Initial: _____
I understand:

- Dental charges are separate and are billed through the dental office.
- I am responsible for payment of all services. Insurance is billed as a courtesy to me.
- If I have insurance benefits, I agree to pay my portion/percentage at the time of service.
- If insurance does not pay the balance in full, I will be billed for the difference. If the insurance pays more than estimated, I will be refunded.
- I agree to pay in full at the time of service if I have no insurance coverage. Initial: _____

Terms: Net 30 days from the date of the invoice, unless otherwise indicated. A finance charge of 1.5% per month (annual rate 18%) of the unpaid balance and our billing fee will be added monthly. Should collections become necessary, the responsible party agrees to pay an additional 40% for collection agency fees and all legal fees of collection, without suit, including attorney fees, court costs and filing fees. IF collections become necessary, all courtesy discounts will be added back to the balance.

Signature of Patient, Parent or Guardian_____ Date _____

FAMILY SURGICAL SUITE
ACKNOWLEDGEMEN OF CONSENT TO
DENTAL SURGERY/DENTAL PROCEDURES

1. I hereby acknowledge the following dental surgery or dental procedure at Family Surgical Suite:
    - Dental Exam
    - Dental Filling(s)
    - Crown(s)
    - Pulpotomy
    - Extraction(s)
    - Other _____

2. That this surgery or procedure is to be performed under the direction of _____
   DDS Name/Number

3. That the doctor has discussed with me, in terms that I understand, the nature and purpose of the procedure, the benefits of the proposed care or treatment, the risks and any dangers or side-effects inherently and potentially involved in undergoing such surgery or procedure Although, I expect the procedure to be performed with no less than customary standard of care, I acknowledge that no guarantee has been made to alternatives. No guarantee or assurance has been given by anyone as to the results that may be obtained from the procedure.
4. In addition, he/she has discussed with me the available alternative to surgery or the procedure which he/she has recommended and the dangers inherent and potentially involved in those alternatives.
5. He/She has discussed with me the dangers inherently and potentially involved if I were to refuse to undergo such surgery or procedure for my child/myself.
6. I understand unforeseen conditions or problems may arise during recuperation and after the proposed care or treatment.
7. I understand that during the course of surgery, unforeseen conditions may be revealed and I authorize additional procedures that are indicated as being necessary for my/child's condition in the best exercise of professional judgement.
8. **Pathology**- I authorize Family Surgical Suite to dispose of any tissues or parts that are removed during the procedure. Family Surgical Suite only performs dental surgeries/procedures in which pathology is exempt.

I am aware that I may ask questions about these procedures, but I do not request any further explanation at this time. Understanding the choice to be mine, I hereby authorize this procedure for myself/child.

Patient name: _____ **Date of Birth**: _____

Patient/Parent/Guardian Name Printed _____

Patient/Parent/Guardian Signature_____ **Date**_____ **Time**_____

Relationship to Patient_____

Dentist Name_____

Dentist Signature _____

FAMILY SURGICAL SUITE
INFORMED CONSENT FOR
SEDATION/GENERAL ANESTHESIA FOR DENTAL TREATMENT

Procedure: *Dental Restorations or Extractions*

As the parent or legal guardian of _____ (patient), I give consent for the use of sedatives, local or intravenous anesthetics, and/or general anesthesia in the treatment of the patient. The options may include IV Sedation, Oral Sedation, and/or General Anesthesia.

I have the option to consult with the anesthesiologist concerning the risks, advantages, disadvantages, probable consequences, probable effectiveness, of sedatives, local and intravenous anesthetics, and general anesthetics, as well as the prognosis if no treatment is provided. I understand that there is some risk. Risks may include but are not limited to:

- Allergic reaction to medications
- Other serious reactions such as Malignant Hyperthermia
- Coexisting illnesses such as asthma, heart disease, neurologic conditions, obesity, or diabetes increase the risk of serious complications.
- Serious side effects such as nausea, vomiting, headache, or prolonged sedation may persist hours to days after the procedure.
- Trauma to teeth, airway, skin, blood vessels or nerves may occur under some circumstances.
- Other reactions may include: infection, swelling, bleeding, discoloration, numbness, pneumonia, or phlebitis.
- Although rare, serious complications may occur such as Malignant Hyperthermia, brain damage, coma, stroke, or heart attack. Such complications may require hospitalization and can result in death.

I understand the preoperative instructions that were given to me and have followed them completely. I have read this consent, understand it and accept the possible risks. The anesthesiologist of Family Surgical Suite is authorized, in his best dental/medical judgment, to use oral, local, or intravenous sedation, general anesthesia, or none of the forgoing, in the treatment of the patient. By signing below, I accept these risks with respect to the procedure listed above.

Furthermore, in the event of a complication I give consent to the medical staff to provide any lifesaving care deemed necessary such as C.P.R., and advanced airway or cardiovascular management.

Patient name: _____ Date of Birth: _____

Patient/Parent/Guardian Printed Name: _____ Date: _____

Patient/Parent/Guardian Signature_____

Relationship to Patient: _____

INFORMATION INFORMED CONSENT ORAL SURGERY AND DENTAL EXTRACTIONS

I UNDERSTAND that ORAL SURGERY and/or DENTAL EXTRACTIONS include possible inherent risks such as, but not limited to the following:

1. **Injury to the nerves:** This may include nerves of the lips, tongue, tissue in the mouth, etc. Numbness may be temporary lasting a few days, weeks, months, or possibly permanent.
2. **Bleeding and/or bruising:** Bleeding may last for several hours. Should it persist, it should receive attention. Bruising may possibly be prolonged.
3. **Dry Sockets:** Occurs on occasion when teeth (usually permanent) are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful.
4. **Sinus involvement:** In some cases, the root tips of upper teeth lie in close proximity to the tissues of the sinuses (usually permanent teeth). During extraction or surgical procedures, this sinus membrane may be perforate. Should this occur, it may be necessary to have the sinuses surgically repaired.
5. **Possible interruption of the developing permanent tooth:** In some cases the primary tooth to be extracted lies in close proximity to the developing permanent successor tooth. During extraction or surgical procedures, the developing tooth's grown membrane and/or the tooth itself may be disturbed causing death of the tooth's pulp tissue rendering the tooth non-vital and possible cessation of growth. This may necessitate that the tooth be removed or a root canal performed.
6. **Infection:** Due to existing non-sterile or infected oral environment, infections may occur postoperatively. Should swelling occur, particularly accompanied with a fever or malaise, seek medical attention as soon as possible.
7. **Root or bone fragments:** A decision may be made to leave a small piece of root or bone fragment in the jaw when its removal would require extensive surgery and/or risk complications.
8. **Bacterial endocarditis:** Due to normal existence of bacteria in the oral cavity, should the tissues of the heart, be susceptible of bacterial infection transmitted through blood vessels, bacterial endocarditits (an infection of the heart) may occur. If any heart problems are known or suspected, inform the doctor.
9. **Unusual reactions to medication given or prescribed:** Reactions, either mild or severe, may possibly occur from anesthetics or medications administered.

I UNDERSTAND that it is my responsibility to see attention for my child should an undue circumstance occur postoperatively, and I shall diligently follow preoperative and postoperative instructions given for my child.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I do voluntarily assume any and all possible risks that my child may incur, including the risk of substantial harm, which may be associated with treatment.

Patient's Name (please print) _____ **Date** _____

_____

Signature of patient/parent/legal guardian/authorized representative

Witness to Signature: _____ **Date:** _____

FAMILY SURGICAL SUITE

MEDICAL ASSESMENT BY PHYSICIAN FOR DENTAL TREATMENT UNDER ANESTHESIA

Name:	□ M □ F	**DOB:**
Care Center:		
Physician Name:		**Physician Number:**

Proposed Dental Treatment:

Dental Provider:	Adam Marberger DDS 4110 South Highland Dr #100B Salt Lake City, UT 84124
□ Preventative/Restorative	□ Local Anesthesia
□ Dental Extraction(s)	□ IV Sedation/MAC
□ Other:	□ General Anesthesia

Patient Is Optimized for Treatment:	
Is the patient currently on blood thinners?	□ YES □ NO
If YES, please give instructions and most recent INR Results:	
Antibiotic Pre-Medication Required?	□ YES □ NO
If YES, please arrange pre-medication and/or instructions:	
Patient is NOT Optimized for Treatment	
Comments:	

X _____ Date: _____

Physician's Signature

FAMILY SURGICAL SUITE
801-833-0515
FAX: 855-224-0040

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff is symptom-free and, to the best of their knowledge, has not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

For the safety of our staff, other patients and your residents in order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below.

_____ _____

On Duty Nurse Signature DATE

PLEASE ANSWER "YES" OR "NO TO THE FOLLOWING QUESTIONS REGARDING YOUR RESIDENT:

HAS YOUR RESIDENT HAD BOTH DOSES OF THE COVID VACCINE? _____YES _____ NO

IF YES, PLEASE PROVIDE DATE OF LAST VACCINE _____. IF **NO** ANSWER QUESTIONS BELOW

HAS YOUR RESIDENT TESTED POSITIVE FOR COVID IN THE **LAST 3 MONTHS?** _____YES _____ NO

IF YES, PLEASE PROVIDE DATE OF POSTIVE TEST: _____ AND INCLUDE A COPY OF THE POSITIVE TEST RESULTS.

IF NO TO QUESTIONS ABOVE, PLEASE ANSWER THE QUESTIONS BELOW:

DO THEY HAVE A FEVER? _____YES _____ NO

DO THEY HAVE ANY SHORTNESS OF BREATH NOT RELEATED TO OTHER DOCMENTED MEDICAL CONDITIONS? _____YES _____ NO

DO THEY A HAVE A DRY COUGH OR SORE THROAT? _____YES _____ NO

DO THEY HAVE A RUNNY NOSE? _____YES _____ NO

WITHIN THE LAST 14 DAYS, HAS ANYONE IN THE FACILITY, INCLUDING EMPLOYEES TESTED POSITIVIE FOR COVID19? _____YES _____ NO

After Hours Scheduling Contact:
Jasmine Westmoland
801-833-0471

FAMILY SURGICAL SUITE

PRE-OPERATIVE INSTRUCTIONS
PLEASE PLACE IN CHART SO ALL STAFF IS AWARE

We ask that our patients follow these instructions strictly so that the anesthetic treatment can go as planned and in the safest conditions. Any neglect or disregard of these instructions may result in the cancellation of the treatment.

Eating and Drinking
Nothing should be ingested after midnight the night before treatment, unless instructed otherwise by the anesthesiologist.

Medications
Please **HOLD** prescribed medications until after treatment, unless the anesthesiologist instructs you otherwise. Medications must be taken with only a sip of water.

Change in Health
We are aware that there may be changes in our patient's health, and it is important to inform our staff if you have a cold or fever. Prior to anesthesia, patients should be in optimal health and treatment may be re-scheduled if there are changes in health.

Escorts
All patients must be accompanied to and from the appointment by a responsible adult. Do not plan to drive a vehicle or operate potentially dangerous equipment for 24 hours after your treatment. Do not take a bus or a taxi home.

Clothing and Makeup
Please wear casual and comfortable clothing, preferably with short sleeves. Comfortable pants or sweat pants should also be worn as well as comfortable flat shoes. Remove all rings and contact lenses. Leave all valuables at home.