



ADULT OUTPATIENT DENTAL PROCEDURE PACKET

REQUIREMENTS:

Patient Information
Informed Consents
Patient Bill of Rights and Privacy Practices
Policies and Authorizations
Medical Clearance Form

STEPS TO COMPLETE:

Review all documents with the responsible party (e.g. POA, guardian, patient).
Ensure **all** forms are **signed** and **dated**.
Return completed packets via email or fax **2 weeks** before procedure.

PRE-OPERATIVE INSTRUCTIONS:

Eating and Drinking:

- Do **NOT** eat or drink anything after **MIDNIGHT** the night before your procedure.

Medications:

- Do **NOT** take prescribed medications, unless your anesthesiologist indicates.
- If approved, medications may be taken with a **small sip** of **water** only.
- **DISCONTINUE ALL BLOOD THINNING MEDICATIONS 5 DAYS PRIOR TO PROCEDURE.**

Health Changes:

- Tell our office if you develop a cold, fever, illness or other health changes.
- Your procedure may be rescheduled if you are not in good health.

Transportation and Support:

- A responsible party must be available to provide transportation after procedure.
 - Patient should be checked regularly for 24 hours following procedure.
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IF YOU HAVE QUESTIONS, CONTACT:

Katie Evans, BSN
Phone: 801-455-2756
Email: katie@caresurgical.org
Fax: 855-224-0040
Care Surgical Main Line: 801-833-0515
Address: 151 E 5600 S Suite 104 Murray, UT 84107



PATIENT INFORMATION

PATIENT INFORMATION

First Name: _____ Last Name: _____
Birth Date: _____ Gender: Male Female Other
Address: _____
City: _____ State: _____ ZIP _____
Email: _____ Phone Number: _____
Marital Status: Married Single Divorced Widowed Other
Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

Name of Insurance Company: _____ State: _____
Member ID: _____ Group: _____
Relationship to Insurance holder: Self Parent Child Spouse Other _____

MEDICAL HISTORY

Is the patient currently under the care of a doctor? Yes No
Doctor's Name: _____ Doctor's Phone Number: _____
Is the patient taking any medications? Yes No Is the patient taking a GLP-1? Yes No
Please list medications (or attach list): _____
Has the patient ever been hospitalized? Yes No
Has the patient had surgery in the past? Yes No
Does the patient have problems with bleeding or bruising? Yes No
Does the patient have any allergies (medicine, food, latex)? Yes No
Please list allergies: _____
What is the patient's current weight? _____
Is the patient wheelchair dependent? Yes No
Is the patient oxygen dependent? Yes No How many liters? _____
Please circle any of the following medical conditions that we should be aware of:
Heart Disease Kidney disease Seizures Cerebral Palsy Cancer
Asthma Liver disease Memory loss Thyroid disease ADD/ADHD
Diabetes Stroke Autism Anemia Other: _____
Current vaccination status: Up to date Not up to date Unknown

Signature of Patient or Responsible Party Relationship to Patient Date

All information on this page is correct to the best of my knowledge



INFORMED CONSENTS

DENTAL TREATMENT CONSENT

I understand that the patient may receive one or more of the following dental treatments at Family Surgical Suite:

- Dental Exam
 - X-rays
 - Crowns
 - Fillings
 - Extractions
 - Pulpotomy (treatment of tooth nerve)
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DENTAL TREATMENT RISKS

I understand that all dental and oral surgery procedures have risks. These may include:

- Pain, swelling, bruising
 - Bleeding or infection
 - Injury to lips, mouth or tongue
 - Temporary or permanent numbness
 - Dry socket after tooth removal
 - Sinus involvement for upper teeth
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GENERAL ANESTHESIA CONSENT

I understand that the anesthesia provider will choose the safest option based on the patient's health and needs. I understand that dental treatment will be done using medicine to reduce pain, anxiety, and awareness. This may include:

- Sedatives
 - IV sedation
 - Anesthesia gases
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GENERAL ANESTHESIA RISKS

I understand that sedation or anesthesia also has risks, including:

- Allergic reactions
 - Nausea and vomiting
 - Headaches and fatigue
 - Heart or blood pressure issues
 - IV site irritation or infection
 - Breathing or airway problems
 - Rare but serious events such as malignant hyperthermia, stroke, brain injury, heart attack, coma, or death
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UNEXPECTED FINDINGS AND EMERGENCY CARE

I understand that unexpected problems may be found during treatment. I give permission for the dental team to perform additional treatment needed for safety and health. If an emergency occurs, I give permission for the medical team to provide necessary lifesaving care, including CPR and airway or heart support.

CONSENT AND SIGNATURE

I voluntarily give permission for the dental treatment and anesthesia described above.

Printed Name of Patient

Signature of Patient or Responsible Party & Relationship to Patient

Date

Signature of Dentist

Date



PATIENT BILL OF RIGHTS AND PRIVACY PRACTICES

PATIENT BILL OF RIGHTS

As a patient of Family Surgical Suite, you have the right to:

- Be treated with respect, dignity, and consideration; and receive care in a safe environment.
 - Receive clear, understandable information about your diagnosis, treatment options, and outcomes.
 - Ask questions and receive answers about your care; and participate in decisions about your care.
 - Refuse treatment, to the extent permitted by law.
 - Expect privacy and confidentiality of your medical information.
 - Expect access to emergency health care services when and where the need arises.
 - Request corrections to your medical records if you believe information is incorrect or incomplete.
 - Receive information about fees, billing, and insurance coverage (including Medicare and Medicaid)
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PRIVACY PRACTICES

Family Surgical Suite is committed to protecting your health information. This summary explains how your information may be used and your rights regarding that information.

We may use or share your health information (called Protected Health Information or PHI) to:

- Provide or coordinate your care.
- Bill for services and process insurance, including Medicare or Medicaid.
- Operate our practice and improve quality and safety.

Other situations where information may be shared:

- Public health and safety purposes, as well as legal or law enforcement requirements.
- Reporting suspected abuse or neglect.
- Emergency situations when consent cannot be obtained.

You have the right to:

- Request confidential communication regarding PHI.
 - Review and request copies of your medical records and request corrections to your medical records.
 - Receive a full copy of our Notice of Privacy Practices at any time.
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QUESTIONS OR CONCERNS

If you have questions about the Patient Bill of Rights or Privacy Practices, please contact:

- Family Surgical Suite Administration: 801-495-1064
- Utah State Health Department: 1-800-662-4157
- Utah State Ombudsman: 801-538-4589



POLICIES AND AUTHORIZATIONS

First Name: _____ Last Name: _____
Birth Date: _____ Gender: Male Female Other

POLICIES

- I have received, read, and understand my rights as a patient as outlined in the Patient Bill of Rights.
 - I understand that Family Surgical Suite does not accept advance directives.
 - I understand that no smoking or tobacco use (including vaping or chewing tobacco) is allowed inside or outside the building from check-in until discharge.
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AUTHORIZATIONS

- I give permission for doctors, nurses, and staff to give medications and provide necessary care.
 - I understand how my medical information may be shared with my insurance company and other healthcare providers involved in my care.
 - I understand that I am responsible for the payment of my care. Insurance is billed as a courtesy to me. If insurance does not pay the balance in full, I will be billed for the difference.
 - I understand that payment is due within 30 days and that unpaid balances may result in additional charges, as allowed by law.
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Signature of Patient or Responsible Party & Relationship to Patient

Date

**Terms: Net 30 days from the date of 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.*