Welcome to our Practice!

Date_____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Dr. Name_____
First MI Last Nickname

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ SS# _____

Address: _____
Street Apt City State Zip

Home # (_____) _____ Cell (_____) _____ Email_____Driver's Lic:_____

Referred by: First Name: _____Last Name: _____

In case of emergency, contact:_____ Relation:_____Tel. (_____) _____

Nearest relative not living with you_____Te.l (_____) _____
First Last

Employer_____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not School Name & Address: _____

Marital Status: ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____
City State Zip

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Employed

PRIMARY INSURANCE COMPANY

Employer: _____

Address: _____
Street City State Zip

Bus. Tel. (_____) _____ Plan: _____

Co. Name:_____ID# _____

Address: _____
Street City State Zip

Bus. Tel. (_____) _____Group # _____ Group Name: _____

Insured Party:_____ Relation: _____

Sex: ❑ Male ❑ Female Birth Date:_____ SS#_____

Address_____ Tel. (_____) _____

DENTAL INFORMATION

Reason for today's visit: _____

_____

Are you in pain? ❑ No ❑ Yes For how long? _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury / extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to:
❑ Hot ❑ Cold ❑ Sweets ❑ Biting

❑ Lost/broken filling(s)
❑ Teeth grinding/clinching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Other: _____

❑ Stained teeth
❑ Locking jaw
❑ Bad Breath
❑ Burning tongue / lips
❑ Toothache

❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth

Last dental exam: _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ N • Height: _____ Weight: _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you ever had generalized anesthesia? ❑ Yes ❑ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Anemia	❑	❑	Abnormal bleeding	❑	❑	Are you on dialysis?
❑	❑	High blood pressure	❑	❑	Asthma	❑	❑	Bleeding tendency	❑	❑	Kidney trouble
❑	❑	Low blood pressure	❑	❑	Mental health problems	❑	❑	Blood transfusion	❑	❑	Sexually transmitted diseases
❑	❑	Mitral valve prolapse	❑	❑	Problems with immune system *(possibly from med. / surg.)*	❑	❑	Blood disorder	❑	❑	Contagious diseases
❑	❑	Heart murmur				❑	❑	Bruise easily	❑	❑	Infectious mononucleosis
❑	❑	Chest pain / Angina	❑	❑	Delay in healing	❑	❑	Eye disease / Glaucoma	❑	❑	Swollen ankles
❑	❑	Heart attacks(s)	❑	❑	Hay fever / Sinus problems	❑	❑	Jaundice / Liver disease	❑	❑	Arthritis / Joint disease
❑	❑	Irregular heart beat	❑	❑	Snoring	❑	❑	Hepatitis B	❑	❑	Prosthetic implant
❑	❑	Cardiac pacemaker	❑	❑	Sleep apnea / CPAP	❑	❑	Hepatitis C	❑	❑	Joint replacement
❑	❑	Heart surgery	❑	❑	Respiratory problems	❑	❑	HIV+	❑	❑	Osteoporosis / Osteopenia
❑	❑	Damaged heart valves	❑	❑	Tuberculosis	❑	❑	Gallbladder trouble	❑	❑	Osteonecrosis
❑	❑	Pneumonia / Bronchitis / Chronic cough	❑	❑	Emphysema	❑	❑	Fainting spells	❑	❑	Stomach ulcers
			❑	❑	Do you smoke? *If yes, # packs per day*_____	❑	❑	Convulsions / Epilepsy	❑	❑	Tumor or growth
❑	❑	Chronic fatigue / night sweats				❑	❑	Stroke	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Trouble climbing 1–2 flights of stairs	❑	❑	Do you use chewing tobacco?	❑	❑	Thyroid trouble	❑	❑	Are you on a diet?
			❑	❑	A history of drug abuse	❑	❑	Diabetes	❑	❑	Contact lenses
			❑	❑	A history of alcohol abuse	❑	❑	Low blood sugar			

MEDICATIONS & ALLERGIES

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Tranquilizers	❑	❑	Stimulants	❑	❑	Are you taking, or have you ever taken, any bone density meds or bisphosphonates such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia or Aredia within the past 12 years?
❑	❑	Diet pills	❑	❑	Muscle relaxers	❑	❑	Antidepressants			
❑	❑	Pain killers (including Aspirin)	❑	❑	Insulin	❑	❑	Blood thinners (Coumadin, Aspirin)			

Please list any other medication(s) you are taking (including natural, herbal or homeopathic products)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or have you had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
			❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex

List other non–drug allergies:

_____

_____

_____

1–4 below for women only: *(Women note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No 2) Expected delivery date:_____

3) Are you nursing? ❑ Yes ❑ No 4) Are you taking birth control pills? ❑ Yes ❑ No

FEES & PAYMENTS An estimate of the charge for any procedure or surgery you may require will be given to you upon request. **It is your responsibility to pay any deductible amount, co–insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in completion of this form. This signature on file is also my authorization for the release of information necessary to process my insurance claim. I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____

Signature of Patient *(Parent or Guardian if Minor)* **Date**

OUR OFFICE AND FINANCIAL POLICIES

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for further information.

APPOINTMENTS

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment a ***48-hour notice*** is expected. A **$50-$100** fee (depending on length of appointment) will be applied for appointments missed without adequate notice. After hours cancellations will be considered next working day. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

INSURANCE

As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, ***we do require you to pay your deductible and/or "estimated copay" at the times of service***. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contrat between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card. We must be able to verify coverage before we can accept the assignment of benefits. When possible, we will submit a dental pre-treatment to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company. We bill your dental insurance company as a courtesy to you. ***I understand that I am responsible for reading and understanding my dental insurance benefits.*** ***Initial:*** _____

USUAL AND CUSTOMARY RATES

Please be aware that some of our services may be "non-covered", and subject to an insurance company's arbitrary determination of usual and customary rates or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. ***You are responsible for any balance left unpaid by your insurance company***. The adult accompanying a minor is responsible for the full payment.

PAYMENT OPTIONS AND ACCOUNT INFORMATION

In order to maintain our fees at a reasonable level, we do not send monthly statements. You will not receive a statement until all insurance claims have been closed. In the event we receive a returned check for insufficient funds or closed account, there will be a $50 fee charged to your account. Collection fees of 40% of the account balance will be added to any balance turned over for collection purposes.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. IN ADDITION, A DEPOSIT MAY BE REQURED FOR LONGER SERVICES SO AS TO PROVIDE THE BEST POSSIBLE CARE.

WE ACCEPT CASH, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER. FINANCING IS AVAILABLE THROUGH CHERRY (ask any staff member for details)

I have read, understand, and agree to the above office and financial policies.

X_____ Date_____

Signature of patient or responsible party

Great Basin
DENTAL

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient Name_____**Birthdate**____/____/____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had the opportunity to read and review a copy of the HIPAA Notice of Privacy Practices for Divine Dental Smile. I understand that I am entitled to receive a paper copy of the Notice if I ask for it.

X_____Date Signed:_____

Signature of Patient, guardian. Or personal representative

If applicable:

Patient's Guardian or Representatives name:_____

Relationship to patient:_____Phone:_____-_____-_____

Permission to Discuss Treatment or Billing Information with:

I give my permission to discuss my treatment and or billing information with:

_____Relationship to patient_____