Patient Information (Confidential)

Welcome to our office! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.

NAME: ________________________ PREFERRED NAME: ____________

EMAIL: ________________________ DOB: / / AGE: ______

MARITAL STATUS: S / M / D / W SEX: □ MALE / □ FEMALE SOCIAL SECURITY #: ______ - ______ - ______

HOME ADDRESS: ________________________ ZIP: __________ STATE: ________

PHONE (HOME): ______________ (WORK): ______________ CELL: ______________

EMPLOYER'S NAME OR SCHOOL NAME: ________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ________________________

EMERGENCY CONTACT INFORMATION: ________________________

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME: ________________________ RELATION TO PATIENT: ____________

ADDRESS: ________________________

SSN#: - - DOB: ____/____/____ GROUP #: ____________ SUBSCRIBER ID#: ____________

EMPLOYER NAME: ________________________

EMPLOYER ADDRESS: ________________________

INSURANCE COMPANY: ________________________

INSURANCE COMPANY ADDRESS: ________________________

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME: ________________________ RELATION TO PATIENT: ____________

ADDRESS: ________________________

SSN#: - - DOB: ____/____/____ GROUP #: ____________ SUBSCRIBER ID#: ____________

EMPLOYER NAME: ________________________

INSURANCE COMPANY: ________________________

INSURANCE COMPANY ADDRESS: ________________________

Have you ever experienced Sedation dentistry? □ **Yes** □ **No**

Would you like to learn more about it? □ **Yes** □ **No**

Would you like your teeth to be whiter? □ **Yes** □ **No**

Have you ever thought about straightening your teeth? □ **Yes** □

RESPONSIBLE PARTY

____

Signature of Patient/Guardian Date

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ____________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ____________

Craig Smith, D.D.S.
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Fax: (208) 388.8462
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FINANCIAL POLICY

We are committed to providing you with exceptional state of the art dentistry, based on your individual needs and always meeting *A Reason to Smile's* standard of care which ensures excellence. To assist you in receiving this care, we offer the following payment options below:

Payment of Services

- ☐ Payment at time of service
  Cash, Check, Visa, MasterCard, American Express, & Discover all accepted
- ☐ Payment Plans are available upon approved credit.

Dental Insurance

We are contracted with the following dental insurance companies: Aetna PPO, Blue Cross of Idaho (Traditional, True Blue, PPO,), Cigna PPO, Delta Dental (Premier& PPO) Guardian DentalGuard PPO, MetLife PDP, and Regence BlueShield of Idaho. *(Insurance contracts may be subject to change)*. Payment of your co-insurance is due at the time of services. Insurance coverage is an **estimate only**. Regardless of insurance coverage you, the patient, are responsible for all fees.

We are happy to file the forms necessary to see that your insurance pays their portion to our office, however, if the outstanding insurance amount due is not received within 30 days, you will be responsible for the balance due.

Missed Appointment Fee

Your appointment time is reserved for you and your dental needs. A $75 missed appointment fee will be charged for missed appointments that are not cancelled prior to 24 hours before your scheduled appointment. If you are more than 15 minutes late you may need to reschedule your appointment and a missed appointment fee may be assessed.

Patient Agreement

I acknowledge that the fee(s) for my dental treatment is my responsibility, and I will assist *A Reason to Smile* in receiving payment from my insurance in a timely fashion. If my account should become delinquent, it may be subject to additional collection charges and fees.

____
Patient Name/Guardian (**PLEASE PRINT**)

X____
Signature of Patient/Guardian Date

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability & Accountability Act of 1996

Federal & state laws require A Reason to Smile (ARTS) to maintain the privacy of all patient healthcare information. ARTS must follow the privacy practices as describes within this notice while this policy is in effect. This notice takes effect on April 14, 2003 and will remain in effect until replaces, amended or eliminated.

ARTS reserves the right to change these privacy practices and the terms of this notice at any time, provided such applicable laws permit such changes. We reserve the right to make any needed changes to our privacy practices and these new terms will be effective for all health information that we maintain, including health information we create or receive before such made changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. A copy of this notice may be requested at any time

USES & DISCLOSURES OF HEALTHCARE INFORMATION

A Reason to Smile (ARTS) will use and disclose patient healthcare information during your treatment, while obtaining payment from insurance companies and during general healthcare operation. For example;

Treatment. ARTS may use your health information during direct treatment or by disclosing such information to other dentists, physicians or healthcare providers who may provide specialized treatment provided you authorize a release of confidential information.

Payment. We may also use and disclose your healthcare information to obtain payment for services rendered. We may disclose your healthcare information to another healthcare provider or entity that is also subject to these federal & state privacy rules & regulations for payment activities

Healthcare operations. We may use or disclose your healthcare information during our routine healthcare operations. Healthcare operations may include quality assessments and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. We may disclose your information to another healthcare provider or organization that is subject to the same federal & state rules and regulations and that has a relationship with you during the support of healthcare operations. We may disclose your information to help such organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals detect or prevent healthcare fraud and abuse.

On your authorization, you may give ARTS written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing, at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give use written authorization, we cannot use or disclose your healthcare information for any reason except these describes within this notice.

Public Benefit. We may disclose your medical/dental information. As authorized by federal or state law for the following purposes deemed to be in the public's best interest or benefit:

- As required by law
- For public health activities, including disease and vita; statistic reporting, reporting child abuse or neglect. FDA oversight, and to employers regarding work-related illness or injury.
- To health oversight agencies
- In response to court and administrative orders and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person.
- To coroners, medical examiners and funeral directors.
- To an organ procurement organization
- To advert a serious threat to health or safety
- In correction institutions regarding inmates.
- As authorized by state workers compensation laws.

QUESTIONS OR COMPLAINTS

I understand the contents of the previous notices concerning the privacy of mine and my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit A Reason to Smile from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

____ ______________

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

____ ______________

SIGNATURE OF WITNESS DATE

HIPPA Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: ____

DOB:____

Signature: ____

Date:____

CONSENT TO PROCEED

I authorize Dr. Craig R. Smith and/or such associates or assistants as 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. After lengthy appointments, jaw muscles may also be sore or tender. 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.

All dental treatment (for those requiring legal guardianship), including routine dental care and restorative treatment for ____________________ must be pre-authorized and consented to by his or her legal guardian; Consent may also be given by ___________________ the caregiver or authorized agent of patient. All medications and prescriptions must also be administered through the authorized agent or in our office upon guardian consent.

Patient Name:____

Signature:____ Date:_____________________
(Patient, legal guardian or authorized agent of patient)