Snake River Dental

PATIENT REGISTRATION

ID: ______________ Date: ____________________

First Name: _____________________ ***Last Name:*** ______________________________ ***Middle Initial:*** __________

Patient Is: ____ Policy Holder
____ Responsible Party

Preferred Name: ____

Responsible Party (If someone other than the patient) ____

First Name: _________________________ Last Name: ______________________________ Middle Initial _________
Address: ______________________________________ Address 2: ____
City, State, Zip: ____ Cellular: _______________
Home Phone: (____) _______ _______ Work Phone: (____) _____ _______ Ext: _____
Birth Date: _______________________ Soc Sec: _______________________ Drivers Lic: _____________________
O Responsible Party is also a Policy Holder for Patient O Primary Insurance Policy Holder O Secondary insurance Holder

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Patient Information:

Address: ____________________________________ Address 2: ____
City: __________________________ State/Zip ___________________________________ Pager: _______________
Home Phone: (____) _____ ______ Work Phone: (____) _____ ______ Ext: ______ Cellular: (____) _____ ______
Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed
Birth Date: _______________ Age: __________ Soc. Sec: _____________________ Drivers Lic: _________________
E-mail: ______________________________________

****We offer a $25.00 credit for each patient referred. Name of patient who referred you:*** ___________________________

________**Section 2** ______________________________________ ________**Section 3**_______________

Employment Status: O Full Time O Part Time O Retired
Medicaid ID: ______________________________
Employer ID: ____________ Pref. Pharmacy: ________________
Carrier ID: ____________________

{ Student Status: O Full Time O Part Time
{ Referred By: ___________________________
{Previous Dentist: ___________________________
{Emergency Contact: ___________________________

Primary Insurance Information

Name of Insured ________________________________ Relationship to Insured O Self O Spouse O Child O Other
Insured ID #: ____________________________________ Insured Birth Date: __________________
Employer ____________________________________
Address: __________________________________
Address 2: __________________________________
City,State,Zip: ________________________________
Rem. Benefits: _________.00 Rem. Deduct: _______.00

{Ins. Company: ______________________________
{ Address: ______________________________
{ Address 2: ______________________________
{ City,State,Zip: ______________________________

Secondary Insurance Information

Name of Insured ________________________________ Relationship to insured O Self O Spouse O Child O Other
Insured Soc. Sec: ________________________________ Insured Birth Date: __________________
Employer ____________________________________
Address: __________________________________
Address 2: __________________________________
City,State,Zip: ________________________________
Rem. Benefits: _________.00 Rem. Deduct: _______.00

{Ins. Company: ______________________________
{ Address: ______________________________
{ Address 2: ______________________________
{ City,State,Zip: ______________________________

TIME 10:43 AM

DATE 7/12/2011

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?

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 ____________

Snake River Dental
James H. Moore, D.D.S.
930 S. 16th St. {Hwy 95}
Payette, ID 83661

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1966 (HIPPA).

The patient understands that:

* Protected health information may be disclosed or used for treatment, Payment, or health care operations.
* This Practice has a Notice of Privacy Practices and that the patient has the opportunity to review the Notice.
* The Practice reserves the right to change the Notice of Privacy Policies.
* The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
* The patient may revoke the Consent in writing at any time and all future disclosures will then cease.
* The Practice may condition treatment upon the execution of this Consent.

I, ________________________________ have received a copy of this office's Notice of Privacy Practices.

Relationship to Patient (if other than patient): ____________________________

________________________________ Date: ______________________
Please sign name

Signed in my presence:____

_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

Snake River Dental Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance, we are always available to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. Minors MUST be accompanied by an adult for all treatment.

We accept CASH, CHECKS, VISA and MASTERCARD. **Financing is also available upon request, prior to treatment.**

In most instances we accept assigned insurance benefits, in which case, YOUR portion of each service is due at the time services are rendered. Those who have dual coverage should discuss their payment plans with the receptionist. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

We will gladly discuss your proposed treatment and answer any questions regarding your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) or the Usual, Customary and Reasonable fees for this region, thus, our fees are considered Usual, Customary and Reasonable by most insurance companies. However, this statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. Should your insurance take longer than 60 days to pay, we would ask that you take care of the balance due and then be reimbursed if and when we receive the insurance payment.

_____ (Please Initial) **I understand that a $35 Service Charge may be incurred for missed appointments and appointments cancelled without 48 hours notice.** Returned checks are subject to an additional fee.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the day the services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. WE ARE HERE TO HELP YOU!

Responsible Party Signature ________________________________ Date ____________