

PLACE A MARK IN THE BOX TO INDICATE ANY OF THE FOLLOWING THAT APPLY:

- | | | |
|---|--|---|
| <input type="checkbox"/> BAD BREATH | <input type="checkbox"/> BLEEDING GUMS | <input type="checkbox"/> JAW PAIN OR TIREDNESS |
| <input type="checkbox"/> MOUTH BREATHING | <input type="checkbox"/> LIP/CHEEK BITING | <input type="checkbox"/> FINGERNAIL BITING |
| <input type="checkbox"/> CHEW FOREIGN OBJECTS | <input type="checkbox"/> CLICKING/POPPING JAW | <input type="checkbox"/> BURNING SENSATION ON TONGUE |
| <input type="checkbox"/> PAIN AROUND EAR | <input type="checkbox"/> GUMS SWOLLEN OR TENDER | <input type="checkbox"/> FOOD COLLECTING BETWEEN TEETH |
| <input type="checkbox"/> PAINFUL BRUSHING | <input type="checkbox"/> PERIODONTAL TREATMENT | <input type="checkbox"/> CHEW ON ONE SIDE OF MOUTH |
| <input type="checkbox"/> SENSITIVITY TO COLD | <input type="checkbox"/> SENSITIVITY TO HOT | <input type="checkbox"/> CIGARETTE, PIPE, OR CIGAR |
| <input type="checkbox"/> CHEWING TOBACCO | <input type="checkbox"/> SENSITIVITY TO SWEETS | <input type="checkbox"/> LOOSE TEETH OR BROKEN FILLINGS |
| <input type="checkbox"/> ORTHODONTIC CARE | <input type="checkbox"/> SENSITIVITY WHEN BITING | <input type="checkbox"/> SORES/GROWTHS IN YOUR MOUTH |

MEDICAL HISTORY

PLACE A MARK IN THE BOX TO INDICATE IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

- | | | |
|----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> ERYTHROMYCIN |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> LATEX | <input type="checkbox"/> LOCAL ANESTHETIC |
| <input type="checkbox"/> SULFA | <input type="checkbox"/> METALS | <input type="checkbox"/> BARBITURATES |

ANY DRUGS/MEDICATION ALLERGIES NOT LISTED ABOVE? _____

WHAT DRUGS ARE YOU TAKING NOW? PLEASE LIST THEM _____

PHYSICIAN'S NAME _____

DATE OF LAST VISIT _____

PLACE A MARK IN THE BOX TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> EXCESSIVE BLEEDING | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> FAINTING/DIZZY | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> ARTIFICIAL VALVES | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> SINUS TROUBLE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART MURMER | <input type="checkbox"/> SKIN RASH |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> HEPATITIS - TYPE _____ | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HERPES | <input type="checkbox"/> SPECIAL DIET |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SWELLING OF THE FEET/ANKLES |
| <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CORTISONE USE | <input type="checkbox"/> NERVOUS PROBLEMS | <input type="checkbox"/> TUMOR/GROWTH |
| <input type="checkbox"/> COUGH PERSISTENT | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> ULCER |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> PREGNANT (NOW) | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> PSYCHIATRIC CARE | <input type="checkbox"/> WEIGHT CHANGES, UNEXPLAINED |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> RADIATION TREATMENT | |

SIGNATURE _____

DATE _____



Our Scheduled Office Hours are:

Monday 8:00 am – 5:00 pm
Tuesday 7:00 am – 4:00 pm
Wednesday 8:00 am – 5:00 pm
Thursday 8:00 am – 2:00 pm

Thank you for choosing our practice. In order to avoid any misunderstandings, Advantage Dental Center provides the following financial policy.

- **Payment is required at the time of service. Accounts over 60 days will accrue a finance charge of 1.5% pr month or 18% per year with a minimum of .50 per month. Any and all accounts over 90 days may be turned over to a collection agency and will accrue a finance charge at the rate of 2% per month or 24% per year. A \$20.00 service fee will be charged to all accounts requiring the services of a third party collection agency.**
- **Insured patients are required to pay the “estimated patient’s portion” at the time of service.**
- Outside financing available.
- We accept Pre-payment for treatment.
- A \$25 fee will be applied on all returned checks.

Insurance Policy:

- The billing of dental insurance companies is a courtesy we provide to our patients free of charge. It is not something we are legally obligated to do.
- Insurance companies **never** pay entire amount of services.
- All policies and benefits are between the insurance company and the policyholder.
- **Any insurance Benefits/Co-pays we calculate are only an estimate based on the information you provide us. Ultimately your insurance is your responsibility.**
- Final responsibility of entire balance rests on the patient regardless of insurance.
- We must emphasize that as a dental care provider, our relationship is with you, the patient NOT with your insurance company.
- Dr. Richins offers an In-house insurance policy for those patients who do not have outside dental insurance benefits.

Cancellation Policy:

- **24 hour** notice is required on all cancellations
- A cancellation fee of **\$50** is applied to patients who do not cancel their appointment prior to 24 hours.

I UNDERSTAND THE POLICIES EXPLAINED TO ME ABOVE AND AGREE TO THESE TERMS.

Signature of Responsible Party

Printed name

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Any questions or concerns about the Notice of Privacy Practices can be directed to Advantage Dental Center, 3043 S. Meridian Rd, Suite #100, Meridian, ID 83642; Attn: Lester Richins.
Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have reviewed a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

- € The patient refused to sign.
- € Due to emergency situation, it was not possible to obtain an acknowledgement.
- € We weren't able to communicate with the patient.
- € Other (Provide specific details)

Employee Signature

Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices.
This form does not constitute legal advice and covers only federal, not state, law.