PATIENT INFORMATION

DATE: _____ HOME PHONE _____ CELL PHONE _____

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

☐ SINGLE ☐ MARRIED ☐ CHILD

BIRTH DATE _____ SSN _____ SEX ☐ MALE ☐ FEMALE

OCCUPATION _____ EMPLOYER _____

PREFERRED PHARMACY _____
LOCATION PHONE

DO YOU WANT TO RECEIVE TEXT MESSAGE REMINDERS ☐ YES ☐ NO

E-MAIL ADDRESS _____

HOW WOULD YOU LIKE TO RECEIVE STATEMENTS? ☐ EMAIL ☐ MAIL ☐ BOTH

WHOM MAY WE THANK FOR REFERRING YOU? _____

WHOM MAY WE NOTIFY IN CASE OF EMERGENCY? _____

RESPONSIBLE PARTY

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

NAME _____

RELATION TO PATIENT _____ BIRTH DATE _____ SSN _____

ADDRESS (IF DIFFERENT FROM PATIENT'S) _____ PHONE _____

CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ WORK PHONE _____

INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURED NAME _____ MEMBER ID _____

GROUP NAME _____ GROUP NUMBER _____

WE ARE HAPPY TO BILL YOUR INSURANCE FOR YOU AS A COURTESY. HOWEVER, YOU ARE ULTIMATELY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY YOUR INSURANCE. ANY QUOTES GIVEN ARE **ESTIMATES** ONLY.

_____
SIGNATURE ACKNOWLEDGING INSURANCE POLICY

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

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

MEDICAL HISTORY

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

- ☐ ASPIRIN
- ☐ PENICILLIN
- ☐ ERYTHROMYCIN
- ☐ CODEINE
- ☐ LATEX
- ☐ LOCAL ANESTHETIC
- ☐ SULFA
- ☐ METALS
- ☐ BARBITURATES

ANY DRUGS/MEDICATION ALLERGIES NOT LISTED ABOVE? _____

WHAT MEDICATIONS ARE YOU TAKING NOW? _____

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT _____

RECENT SURGERIES (PROCEDURE, MONTH & YEAR) _____

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

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

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

_____ Date _____

Printed name

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.