555 W Canfield Ave, Coeur d'Alene, ID 82815
208-762-8750

Patient Information:

Patient Name: ____ Preferred Name: _________________________________

Birth Date: ______________________ Male: _____ Female: _____ Married: _____ Single: _____ Minor: Y N

SS#: ____ Driver's License #: ______________________________________

Address: ____ City: _____________________ State: _______ Zip: ___________

Home Phone #: ______________________ Work #: _______________________ Cell #: ______________________________

E-mail address: _______________________________________ Best way to reach you: ______________________________

Employer: ____

Emergency Contact: ___________________________________ Phone #: ____

Other family members seen by us: ____

How did you hear of us? ____

If referred by someone, whom may we thank for the referral? ____

Parent/Guardian Information (if patient is a minor):

Name: ____ Relationship to patient: ______________________________

Birth Date: __________________ SS#: _____________________________ Driver's License #: _________________________

Address: ______________________________________ City: ________________________ State: ______ Zip: ___________

Home Phone #: ______________________ Work #: _________________________ Cell #: ____________________________

Dental Insurance Information (Primary):

Policyholder's Name: ________________________________ Birth Date: ______________ SS#: _______________________

Insurance Company: ____ Group #: ______________________________

Employer: ____ Policyholder's ID#: ___________________________________

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Dental Insurance Information (Secondary):

Policyholder's Name: ________________________________ Birth Date: ______________ SS#: _______________________

Insurance Company: ____ Group #: ______________________________

Employer: ____ Policyholder's ID#: ___________________________________

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Do you like your smile? Yes No

What, if anything, would you change about your smile? ____

Why have you come to the dentist today? ____

Are you currently in pain? Yes No Do your gums bleed? Yes No How many times a day do you brush? _________

Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Yes No

Have you ever had problems with previous dental treatment? Yes No

If yes, please explain: ____

Previous Dentist or Dental Office: _________________________________ When was last dental visit? ____________

Do you smoke or use chewing tobacco? Yes No If yes, how long? _____________ How often? _________________

Physician's Name: ____ Phone #: _______________________________

Have you ever had a serious head, neck, or back injury? ____

WOMEN: Are you or could you be pregnant? Y N Are you nursing? Y N Taking Oral Contraceptives? Y N

Are you currently being treated for or have you ever been treated for any of the following? Please circle all that apply:

Rheumatic Fever	Epilepsy/Seizures	Tuberculosis	Hepatitis	Low Blood Pressure
Heart Murmur	Diabetes	Asthma	HIV/AIDS	High Blood Pressure
Mitral Valve Prolapse	Glaucoma	Sinus Problems	Blood Transfusion	Heart Attack/Stroke
Artificial Valve/Joint	Arthritis	Cancer/Chemo	Drug/Alcohol Abuse	Pacemaker
Any implant/transplant	Kidney Problems	Severe Headaches	Psychiatric Care	Excessive bleeding/Bruise easily
Thyroid problems	Heart surgery	Autism		

Please list any medical condition not listed above: ____

Are you allergic to any of the following? PLEASE CIRCLE YES or NO FOR EACH ONE.

Latex Y N Penicillin Y N Aspirin Y N Erythromycin Y N Codeine Y N Tetracycline Y N

Ibuprofen Y N Tylenol Y N Sulfa Y N Dental Anesthetics Y N

Other ____

Please list all medications you are currently taking: ____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: ____ Date: ________________________

Parent/Guardian Signature **if patient is a minor**: ____ Date: ____________

Consent for Services:

As a condition of treatment by this office, ***all financial arrangements <u>must</u> be made in advance.*** The practice depends upon collection from patients for the costs incurred for their care. An estimate of financial responsibility on the part of each patient will be determined before treatment.

All emergency dental services, or any dental services performed without previous arrangements, must be paid for at the time of service.

Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your dental insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay. ***It is our office policy to collect patient's estimated portion at the time of service***.

I have read and understand the above conditions of treatment and payment; I agree and give my consent for treatment.

Signature: ____ Date: __________________________

Missed appointments/Short notice cancellations

Without 48 hours advance notice, there will be a fee of $50 for any missed appointment. The missed appointment fee must be paid prior to future office visits. ________ (please initial)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2012, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. You may contact us to request more information about our privacy practices.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use or disclose your health information to obtain payment for services we provide you. We may use and disclose your health information with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications certification, licensing or credentialing activities.

Signature: ____ Date: _______________________________

HIPAA COMPLIANCE:

In compliance with the Federal HIPAA policy we are requesting your permission to send out appointment reminders via postcards to the address on file. These postcards will have your name, address, time, and date of the appointment viewable by the post office.

I give Delwyn Dick DDS. permission to send appointment reminders via all form of communication including but not limited to email, text, and mailers.

Patient/Guardian Signature ____ Date _____________