Kootenai Dental Group

Dr. Delwyn Dick and Dr. Lamont Murdoch

Patient Registration Form

Patient Information:

Patient Name: _____ Preferred Name: _____

Birth Date: ___/____/_____ Male ❒ Female ❒ Married ❒ Single ❒ Minor ❒

SSN#: _____-_____-_____ Email address: _____@_____

Address: _____ City: _____ State:_____ Zip: _____

Home # (_____) _____ Cell# (_____) _____ Best Way to Reach me: Text ❒ Call ❒

How did you hear of us? _____

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

Emergency Contact: (Guardian Information if Minor)

Name: _____ Relationship to Patient: _____

Birth Date: ___/____/_____ Cell# (_____) _____ Best Way to Reach me: Text ❒ Call ❒

Financial / Insurance ❒ No Insurance / Self pay

Primary Dental Insurance Information:

Policy Holder: _____ Birth Date: ___/____/_____ SSN#: _____-_____-_____

Relationship to Patient: Self ❒ Spouse ❒ Child ❒ Employer: _____

Insurance Company: _____ ID# _____ Group #_____

Secondary Dental Insurance Information:

Policy Holder: _____ Birth Date: ___/____/_____ SSN#: _____-_____-_____

Relationship to Patient: Self ❒ Spouse ❒ Child ❒ Employer: _____

Insurance Company: _____ ID# _____ Group #_____

Medical and Dental History:

❒ Asthma	❒ Arthritis	❒ Artificial Valve/Joint	❒ Autism	❒ Bleed/Bruise Easily
❒ Blood Transfusion	❒ Cancer / Chemo	❒ Diabetes	❒ Drug/Alcohol Abuse	❒ Epilepsy/ Seizure
❒ Glaucoma	❒ Heart Attack	❒ Heart Murmur	❒ Heart Surgery	❒ Hepatitis
❒ High Blood Pressure	❒ HIV/AIDS	❒ Implant / Transplant	❒ Kidney Problems	❒ Low Blood Pressure
❒ Mitral Valve Prolapse	❒ Pacemaker	❒ Psychiatric care	❒ Rheumatic Fever	❒ Severe Headaches
❒ Sinus Problems	❒ Stroke	❒Thyroid Problems	❒ Tuberculosis	

Please list any medical condition not listed here: _____

Please list all medications you are currently taking here: _____

_____

If you have a list, please bring to the front desk and we will scan into your chart.

Are you allergic to any of the following?

❒ Aspirin ❒ Codeine ❒ Dental Anesthetics ❒ Erythromycin ❒ Ibuprofen ❒ Latex

❒ Penicillin ❒ Sulfa ❒ Tetracycline ❒ Tylenol ❒ Other _____

Why have you come to the dentist today? _____

Are you currently in pain? ❒ YES ❒ NO Do your Gums Bleed? ❒ YES ❒ NO

Do you brush your teeth twice a day ❒ YES ❒ NO Do you floss regularly ❒ YES ❒ NO

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: _____

When was your last dental visit? _____

Have you ever had a serious head, neck, or back injury? ❒ YES ❒ NO

Medical Physician: _____ Phone #_____

WOMEN Are you or could you be pregnant? ❒ YES ❒ NO *If yes, how many weeks?* _____ Nursing? ❒ YES ❒ NO

General Consent

1. During the course of treatment, I may undergo procedures in all phases of dentistry. Some of the procedures may be performed by a dental profession other than the dentist including a dental assistant or dental hygienist that have been trained and certified by the State of Idaho.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. *Payment is due the day of service* and *I am responsible for the full amount owed regardless of any insurance policy* I may or may not have. The practice will help in filling any forms needed for insurance reimbursement and those payments will be given to the patient. There is no guarantee that an insurance company will cover work that may be performed.

5. PHOTO CONSENT: I grant permission for Dr. Delwyn Dick and Dr. Lamont Murdoch for the use of the photograph(s) or electronic media images for educational purposes and in any presentation of any and all kinds including marketing. *(This will be of your smile only and not full-face photos.)*

6. Missed appointments/Short notice cancellations: Without 48 hours advance notice, there will be a fee of $50 for any missed appointments. The missed appointment fee must be paid prior to future office visits.

7. HIPAA Compliance: I grant Delwyn Dick DDS permission to send out all reminders via all forms of communication by the information I have provided whether phone, email or mailing.

8. Notice of Privacy Practices:

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 took 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.

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.

Patient/Guardian Signature: _____ Date: _____

To help us serve your dental needs best, we would like to know more about you.
Please take a moment to complete the following questions:

- Do you experience any apprehension before or during dental visits? If so, please explain.
  _____

- On a scale of 1-10 (10=highest), how would you rate your dental health?
  _____

- Have you ever had gum disease? Has anyone in your family suffered from gum disease?
  _____

- What is your biggest dental health concern?
  _____

- Have you or anyone in your family been diagnosed or treated for oral cancer?
  _____

- Are there foods you enjoy but cannot eat due to discomfort with your teeth?
  _____

- If you could improve anything about your smile what would that be?

  _____