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DENTAL

Section I: Patient Information Date_____

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
Date of Birth: _____SS#:_____Sex:M_____F_____
☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
How did you hear about our office? _____
Person to contact in case of emergency_____ Phone_____
Email Address:_____

Section II Responsible Party (If different from above)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State:_____ Zip:_____ Phone:(____)_____
Employer_____ Work Phone(____)_____DOB_____SS#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SS#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ Ins Co. Phone:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured_____DOB_____Relationship to Patient _____

SS#:_____ Name of Employer: _____ WorkPhone: (____) _____

Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

I have read and/or received and understand the financial policy and The Notice of Privacy Practices. I authorize Emmett Dental to take x-rays or other diagnostic aids to make a thorough diagnosis. I also authorize the doctor to perform any and all forms of treatment deemed fit to correct diagnosis. I understand that the use of anesthetic and certain treatment embody some risk. I hereby give permission to Emmett Dental to release my dental records to my insurance company or specialist I may be referred to.
Sign: _____ Date:_____

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Patient Name: _____ **Date of Birth** _____

Previous Dentist_____ **Date of last dental visit**_____

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling? (Here or elsewhere)

___Cost ___No time ___Didn't hurt/ Didn't think I needed treatment
___Fear of pain ___No insurance ___Other (please explain)_____

HEALTH HISTORY

Check if you have or had any of the following:

___AIDS
___Anemia
___Arthritis
___Artificial Heart Valve
___Artificial Joints
___Asthma
___Back Problems
___Cancer, Tumor Malignancy
___Chemical Dependency
___Chemotherapy
___Circulatory Problems
___Cortisone Treatments
___Cough up blood
___Congenital Heart Disorder
___Cough, Persistent
___Diabetes
___Epilepsy, Seizures
___Fainting, Dizziness
___Glaucoma
___Headaches
___Heart Attack
___Heart Murmur
___Hepatitis, Type____
___Herpes
___High Blood Pressure
___HIV Positive
___Hospitalization
___Immune Disorder
___Jaundice
___Kidney Disease
___Liver Disease
___Lung Disease
___Major Surgery, Type _____
___Mitral Valve Prolapse
___Nervous Problems
___Pacemaker
___Pain in Jaw Joint
___Prolonged Bleeding Disorder
___Psychiatric Care
___Radiation Treatment
___Respiratory Disease
___Rheumatic Fever
___Scarlet Fever
___Shortness of breath
___Sinus Trouble
___Skin Rash
___Stroke
___Swelling of Feet or Ankles
___Taking Fen-Phen or
___Thyroid Problems
___Tobacco Habit, Type _____ How much_____
___Tonsillitis
___Tuberculosis
___Ulcer
___Venereal Disease
___Are you Pregnant? Due Date _____

Medications
List medications you are currently taking:
(Include oral contraceptives and alternative medicines)
_____
_____
_____
_____
_____

Allergies
___Aspirin
___Barbiturates
___Codeine
___Latex
___Local Anesthetic
___Penicillin
___Sulfa
___Other _____

Have you taken Bisphosphate for bone density, such as: Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Reclast, Zometa? _____

Do you have cancer?_____ If so have you been treated?_____

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of Emmett Dental & Orthodontics responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Financial Policy

Thank you for choosing Emmett Dental as your dental care provider! Our professional dental team is committed to providing you excellent dental care in a friendly, comfortable setting. The following is a statement of our financial policy, which we request that you read and sign prior to treatment.

Full payment is due at the time of service. We accept cash, check, debit cards, Visa, MasterCard, Discover, American Express, and Care Credit. Interest on balances unpaid beyond 90 days will be applied at the rate of 1.5% monthly (18% annually). ***While we do accept assignment of insurance benefits, your portion of each service is due at the time services are rendered. This may be based on an estimate of insurance payment.***

Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. We do, however, submit dental claims as a courtesy to our patients and will do our best to assist you in understanding and applying your dental benefits. ***We cannot guarantee insurance payments or payment amounts. All treatment estimates are provided based upon information from your insurance company and are estimates only.*** If your insurance company has not paid your account in full within 90 days of billing, we will require the balance to be paid directly by you via cash, check, debit or credit card.

Treatment plans are created based upon clinical findings during your diagnostic exam and are subject to change based upon clinical need and/or our treatment schedule.

Our policy is to charge for missed appointments, or appointments that are cancelled less than a 24 hour notice at the rate of $25.00 per appointment. Please help us serve you better by keeping scheduled appointments.

Returned checks are subject to an additional fee of $25.00. Unpaid balances are subject to action by a collection agency.

Signature on File

By signing below, I give my permission for Emmett Dental to release necessary information regarding my treatment to my insurance company(s) and assign dental benefit payments directly to Emmett Dental.

If you have any further questions regarding our financial policy, please ask a member of our dental team.

I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.
Printed Name: _____ **Date:** _____
Signature:_____

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DENTAL

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed. It also explains how to obtain access to this information. Please review it carefully.

The Health Information Portability and Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of the health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization reviews. For example, we disclose treatment information when billing insurance for your treatment.
Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending postcards and/or leaving messages at home/work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Office at the practice address listed below.
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless y you agree in writing to remove it. The right to request to received confidential communications of protected health information from us by alternative or at alternative locations. The right to access, inspect, and copy your protected health information. You have the right to request an amendment to your protected health information. The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 15, 2003** and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revises Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

507 S Washington Ave
Emmett, Idaho 83617

For more information about HIPPA or to file a complaint:

US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, DC 20201
(877)696-6775 (toll free)

EMMETT DENTAL GROUP ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

(Please check one of the following)

*I have received a copy of this office's notice of Privacy Practices _____

*I have reviewed the notice of Privacy Practices, but declined my copy _____

Please print name

Signature Date

For office use only

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)_____
  _____

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DENTAL

507 S Washington Ave Emmett, Idaho 83617

RECORD RELEASE REQUEST

Please release my dental records:

Name: _____

Address: _____

_____

Date of Birth: _____

From Previous Dental Office : _____

Address: _____

_____

Phone: _____ Fax: _____

To: Emmett Dental

Address: 507 S Washington Ave

Emmett, Idaho 83617

Phone: 208-365-6313

Signature: _____
Date: _____