BOISE PROSTHODONTICS

MICHAEL LYNN GURNEY, DDS, MS
CHRISTOPHER JONES, DMD, MS, FACP
1803 SOUTH TOPAZ WAY, SUITE 120
MERIDIAN, ID 83642
office@boiseprosthodontics.com
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Patient Information

Today's Date _____

First Name _____ MI _____ Last Name _____

Preferred Name _____ Birthdate _____ SS# _____

Gender: ☐ Male ☐ Female ☐ Unspecified Marital Status: ☐ Single ☐ Married ☐ Widowed

Home Phone _____ Cell Phone _____

Employer _____ Employer Phone _____

Address

Street Address _____

City _____ State _____ Zip Code _____

Email _____

Emergency Contact

Name _____ Phone _____

Relationship _____

Your Primary Physician

Name _____

Phone _____

Date & Reason Of Last Visit _____

_____

Your Primary Dentist

Name _____

Phone _____

Date & Reason Of Last Visit _____

_____

Preferred Pharmacy

Name _____ Location _____

What is your appointment reason? _____

_____

Who referred you to our office? ☐ Doctor ☐ Patient ☐ Self

Name of referring Doctor or Patient _____

Health History

1. Do we have your permission to consult with your physician? ☐ Yes ☐ No

2. Are you under medical treatment at this time? ☐ Yes ☐ No

If yes, please explain:

3. Have you been hospitalized or had a serious illness within the last year? ☐ Yes ☐ No

If yes, please explain:

4. Have you ever been advised to take antibiotics before a dental appointment? ☐ Yes ☐ No

If yes, please explain:

5. Have you had any serious medical trouble associated with any dental experience? ☐ Yes ☐ No

If yes, please explain:

6. Do you have any artificial joints? ☐ Yes ☐ No

If yes, which joints: _____

Replacement dates: _____

7. Do you have cancer? ☐ Yes ☐ No

If yes, type and location: _____

Have your received any of the following treatments:

☐ Surgical Treatment ☐ Chemotherapy ☐ Radiation Therapy

8. Do you have diabetes? ☐ Type I ☐ Type II ☐ No

Do you require insulin therapy? ☐ Yes ☐ No

How often do you test your blood sugar? _____

Last HbA1c value?_____ Date of last HbA1c? _____

How often is your HvA1c tested? _____

9. Are you taking or have you taken any Bisphosphonates? (Fosamax, oniva, Actonel, Reclast, ect.)

☐ Yes, oral ☐ Yes, intravenous ☐ No

Reason for use: _____

How long have you used them: _____

10. **Women only:** Are you pregnant? ☐ Yes ☐ No Expected delivery date: _____

Are you nursing? ☐ Yes ☐ No

Are you going or have you gone through menopause? ☐ Yes ☐ No

11. Do you currently use tobacco? ☐ Yes ☐ No

☐ Cigarettes ☐ Chew ☐ Cigars ☐ Vape

How much per day?_____ Years of use? _____

12. Do you have a past history of tobacco use? ☐ Yes ☐ No

When did you quit? _____

Do you have or have you had any of the following health conditions?
Please check all the boxes that apply.

- ☐ Artificial Joint Replacement
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Congenital Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Angina Pectoris (Chest Pain)
- ☐ Atherosclerosis
- ☐ Pace Maker
- ☐ Rheumatic Fever
- ☐ Blood Transfusion
- ☐ Abnormal Bleeding
- ☐ Blood Disorder
- ☐ Positive HIV, AIDS, AIDS Complex
- ☐ Tuberculosis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Stroke
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Acid Reflux/GERD
- ☐ Hay Fever
- ☐ Lung Disease
- ☐ Sinus Problems
- ☐ Glaucoma/Impaired Eyesight
- ☐ Kidney Condition: Shunt/Dialysis
- ☐ Autoimmune Disorder
- ☐ Arthritis
- ☐ Allergies
- ☐ Cortisone Therapy
- ☐ Depression
- ☐ Anxiety
- ☐ Frequent Headaches/Migraines
- ☐ Recreational Drug Usage
- ☐ Alcohol Addiction
- ☐ Seizures
- ☐ Epilepsy
- ☐ Liver Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Organ Transplant
- ☐ Parkinson's Disease
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Jaw Joint Pain

If yes to any of the above conditions, please explain:

Allergies

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Jewelry
- ☐ Tetracycline
- ☐ Codeine
- ☐ Latex
- ☐ Sulfa
- ☐ Dental Anesthetic
- ☐ Metals
- ☐ Barbiturates
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Tranquilizers

Please list any medications you've experienced adverse reactions to:
(nausea, dizziness, hives, rash, difficulty breathing, ect.)

List any mediations you are taking including non-prescription, herbal, vitamins & supplements:

Medication	Dosage	Reason For Taking

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Financial Agreement

Payment is always due at the time services are rendered. At every office visit, please be prepared to pay the full amount unless prior arrangements have been made in advance with our office. For your convenience, our office accepts checks, cash, all major credit cards, and some care credit options. There is a $20 fee for all returned checks. If you have any questions about your account with us or other financial concerns, please feel free to ask us at anytime. We keep a five year history of all financial transactions relating to your account.

Once you have accepted a definitive treatment plan with Boise Prosthodontics, a retainer fee will be required prior to the commencement of treatment. This retainer fee will be discussed with our financial coordinator at the time you accept treatment. The remaining fees associated with your treatment must be paid in full at the time each step of treatment is completed. Often, treatment may last over several months, so we encourage our patients to make payments towards the treatment balance plan prior to the completion date of each step of treatment. Amounts due on your account which remained unpaid upon sixty (60) days after the due date will accrue interest at the rate of 0.75 % per maximum amount allowable by law, whichever is less.

As a courtesy to our patients, we will file insurance claims on your behalf with your dental insurance company only. We do not file claims with any medical insurance providers. Please ensure that our office has all current insurance information on file. Despite the fact that payment is required at the time treatment is rendered, we will still submit the claim to your insurance for reimbursement. In the event we are successful obtaining reimbursement from your insurer, we will credit such reimbursements to your account or issue a refund if your account has been paid in full. Please know that your insurance policies are contracts between you and your insurance company and we are not a party to such contracts. Therefore, it is your sole responsibility to call your insurers to inquire about your personal benefits, payments made on account, or any other insurance related matters. Boise Prosthodontics will use reasonable efforts to make you aware of any reimbursements, denial of claims, and other correspondence we have received. Please feel free to inquire during your visit to our office.

Parents and/or legal guardians are responsible for full payment for minors at the time services are rendered, whether such minor is accompanied by a parent or legal guardian for any appointment.

We will make every effort to accommodate your scheduling requests within our normal business hours. In return, we ask that you help us by keeping your scheduled appointments or by notifying us at least 48 hours in advance if you are unable to keep your scheduled appointment. In the event you fail to provide proper notice, a charge of $50 per scheduled hour will be made to your account. Please note that in order to ensure that your appointment is properly rescheduled, we do not accept cancellations of scheduled appointments by voicemail message.

Authorization & Signature:

I hereby certify that I have read and understand the foregoing financial policies. I acknowledge that I am and will remain personally responsible for all charges relating to my treatment (or the treatment of a minor for which I am legally responsible) and agree to pay all outstanding balances on my account accordingly to such financial policies. I further agree to pay all attorney fees, court costs, and other collection related expenses incurred by Boise Prosthodontics in efforts to collect on my account.

Signature _____ Date _____

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Patient Rights & HIPAA Authorization

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time “HIPAA".

Tell your provider if you do not understand this authorization, and the provider will explain it to you.

You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address: 1803 S Topaz Way, Suite 120, Meridian, Idaho 83642

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

Once the information about you leaves this office, according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA or covered by federal privacy regulations. The information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Authorization and Signature:

I authorize the release of my confidential protected dental information. As described in my directions above, I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature _____ Date _____

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Photo & Video Consent

First Name: _____ **Last Name:** _____

Boise Prosthodontics strives to ensure that we provide the highest quality of care to people in need. Part of providing that care is educating and helping others understand what services and options may be available to them. As such, we are asking your permission to use your photos and/or video for training and education purpose of future patients and other dental professionals.

I consent to the following:

- ☐ Photography
- ☐ Testimonial Video

For the following use:

- ☐ Public use
- ☐ Office use only

Public use may consist of the following:

- Publication in newspapers, magazines, or other printed publications
- Online use such as our website or social media platforms
- Broadcast by radio or television
- Boise Prosthodontics marketing and public relations materials

I understand the following:

- I may refuse to sign the authorization and understand that my testimonials are strictly voluntary
- If I decline these options, my health care and the payment for my health care will not be affected
- I may revoke this authorization at any time and it will not have any effect on any actions taken prior to receiving the revocation

I have read and authorize the disclosure of the protected health information as stated:

I relieve and hereby agree to hold Boise Prosthodontics and the facility free and harmless from any and all liability arising out of the use and/or release of information: interview, photograph/video, and subsequent publication or broadcast. I understand that the interviews or photo sessions are being carried out upon my consent and authorization and so assume full responsibility.

Signature _____ Date _____