BOISE
PROSTHODONTICS

MICHAEL LYNN GURNEY, DDS, MS
CHRISTOPHER JONES, DMD, MS, FACP
1803 S. TOPAZ WAY, SUITE 120
MERIDIAN, ID 83642
office@boiseprosthodontics.com
www.smileagainidaho.com • 208-376-0567

Patient Information

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ DOB: _____ SS#:_____

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

Name of Spouse: _____DOB:_____SS#:_____

Home Phone: _____ Cell Phone: _____

Employer: _____ Employer Phone: _____

Address

Street Address _____

City _____ State _____ Zip Code _____

Email _____

Emergency Contact

Name _____ Phone _____

Relationship _____

Primary Physician

Name _____

Phone _____

Date & Reason Of Last Visit _____

_____

Primary Dentist

Name _____

Phone _____

Date & Reason Of Last Visit _____

_____

Preferred Pharmacy

Name _____Location _____Phone_____

What is your appointment reason? _____

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

Name of referring Doctor or Patient _____

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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. CANCER? ☐ Yes (Current) (Past) (*circle current or past*) ☐ No

Type and location: _____

8. Have you received any of the following Cancer treatments?

☐ Surgical Treatment ☐ Chemotherapy ☐ Radiation Therapy

9. Do you have DIABETES? ☐ NO ☐ Type I ☐ Type II

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 HbA1c 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: _____

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

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

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Allergies:

Are you allergic to any of the following....what is the reaction? *(rash, hives, etc.)*

☐ Dental Anesthetic_____	☐ Jewelry_____	☐ Codeine_____
☐ Latex_____	☐ Sulfa_____	☐ Metals_____
☐ Penicillin_____	☐ Erythromycin_____	☐ Tranquilizers_____

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

List current medications 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.

We do our best to confirm our patient's appointments by phone, text message or email. We strive to create a schedule that most efficiently provides for the dental needs of all the patients we serve. We respectfully request 24 hours' notice to reschedule or cancel an appointment. This allows us the time to fill the appointment with a patient that is on the waiting list and to better serve the needs of all of our patients. **A late cancellation or missed appointment may be subject to a $50 cancellation fee.** We understand that situations occur that may hinder you from keeping your appointment and we are willing to work with you to find an appointment that works best with your schedule.

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.

Although we do not contract with any insurance companies, (this means we are considered out of network), as a courtesy, we will file insurance claims on your behalf to your dental insurance 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. If insurance does pay, the reimbursement check will be sent directly back to you. 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

BOISE PROSTHODONTICS

Smile AGAIN. Eat AGAIN. Live AGAIN.

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize BOISE PROSTHODONTICS to release my records and any information requested to the following individuals.

1. _____ **Relation to Patient:**_____ **Phone Number:**_____
2. _____ **Relation to Patient:**_____ **Phone Number:**_____
3. _____ **Relation to Patient:**_____ **Phone Number:**_____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments and financial information.

____ I authorize you to leave a message with anyone who answers the phone and are named above.

Diagnostic Photos:

*As part of the records collection process, diagnostic photos will be taken before and after treatment. They will be only be shared with the referring doctor as they will be included in the completion letter.

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature