**bOISE PROSTHODONTICS**

**PATIENT INFORMATION**

|  |  |  |
| --- | --- | --- |
| Today's Date: |   |   |
| FIRST Name: | MI/Middle: | LAST Name:  |
|   |   |   |
| Preferred Name: | DOB:  | Age: |
|   |   |   |
| Gender:  | SSN: | Marital Status:  |
|   |   |   |
| Address: | City & State: | Zip Code: |
|   |   |   |
| Mobile Phone: | Home Phone: | Other: |
|   |   |   |
| Emergency Contact Name: | Phone: | Relationship: |
| Ok to text to mobile: [ ] ***YES*** [ ]  **NO** | Email: |   |
|  |  |  |
|  |  |  |

***Dental INSURANCE ONLy***

***(Please give your insurance card to the front Desk)***

|  |  |  |
| --- | --- | --- |
| Subscriber's name: | Subscriber's SSN: | DOB: |
|  |  |  |
| Group #: | Subscriber ID:  | Relationship to subscriber:  |
|  |  |  |

**Other information**

|  |  |  |
| --- | --- | --- |
| Dentist Name: | Office Phone: | Location: |
|  |  |  |
| Physician Name: | Office Phone: | Specialty: |
|  |  |  |
| May we contact your physician? [ ]  **YES** [ ]  **NO**  |  |
|  |  |  |
| Preferred Pharmacy: | Phone: | Location: |
|  |  |  |
| Whom can we thank for referring you?  | [ ] **Self** [ ]  **Dentist** [ ] **Patient**  | Name:  |

***Reason for your visit today:***

**Health history**

|  |
| --- |
| Are you currently under medical treatment?[ ]  **YES** [ ]  **NO**  |
| ***If YES, please explain:***  |
| Have you been hospitalized or had a serious illness within the last year?[ ]  **YES** [ ]  **NO** |
| ***If YES, please explain:*** |
| Have you had any serious medical issues associated with dental treatment?[ ]  **YES** [ ]  **NO**  |
| ***If YES, please explain:*** |
| Do you have any **ARTIFICIAL JOINTS**?[ ]  **YES** [ ]  **NO** |
| *If yes, which joints?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Replacement dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Does your doctor require a **PRE-MEDICATION** before dental treatment?[ ] **YES** [ ]  **NO***If* ***YES****, which antibiotic do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **CANCER**: [ ]  **NO** [ ]  **YES, CURRENT** [ ]  **YES, PAST***Type, Dates & Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Type of treatment:* [ ] **Surgical** [ ]  **Chemotherapy** [ ]  **Radiation** |
|  |
| ***DIABETES****:* [ ] **NO** [ ]  **YES** [ ]  **TYPE I** [ ]  **TYPE II**Are you insulin dependent? [ ]  **NO** [ ]  **YES** Last blood sugar reading: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last HbA1c:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Are you currently taking* ***BISPHOSONATES****?*(Fosamax, Boniva, Actonel, Reclast, etc.)[ ]  **NO** [ ]  **YES, pills** [ ]  **YES, intravenous***Reason for use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How long have you been on it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

**List any surgeries:**

**Health history Cont'd**

|  |
| --- |
| **WOMEN ONLY:** Are you pregnant?[ ]  **YES** [ ]  **NO**  |
| ***If YES, expected delivery date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Are you nursing?*[ ] **YES** [ ]  **NO***Are you going through MENOPAUSE?* [ ]  ***YES*** [ ] **NO**  |
| **TOBACCO USE**: [ ]  **YES-CURRENT** [ ]  **NO-PAST** [ ]  **NO** *Years of use***:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*What type:*[ ]  **Cigarettes** [ ]  **Chewing tobacco** [ ]  **Cigars** [ ]  **Vape**How many per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |

 **\**Please mark all the health conditions that apply below.***

[ ]  Artificial Joint Replacement

 [ ]  Knee

 [ ]  Hip

 [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Heart Attack

[ ]  Heart Stent

[ ]  Congenital Heart Disease/Failure

[ ]  Mitral Valve Prolapse

[ ]  Angina Pectoris (Chest Pain)

[ ]  Stroke/TIA

[ ]  Heart Murmur

[ ]  Pacemaker

[ ]  Rheumatic Fever

[ ]  High Blood Pressure

[ ]  Low Blood Pressure

[ ]  High Cholesterol

[ ]  Blood Transfusion/Blood Disorder

[ ]  Abnormal Bleeding

[ ]  Positive HIV, AIDS, AIDS complex

[ ]  Tuberculosis

[ ]  Hepatitis A [ ] Hepatitis B [ ] Hepatitis C

[ ]  Asthma

[ ]  Emphysema

[ ]  COPD

[ ]  Oxygen Use

[ ]  Acid Reflux/GERD

[ ]  Lung Disease

[ ]  Seasonal Allergies

[ ]  Sinus Issues

[ ]  Glaucoma/Impaired Eyesight

[ ]  Kidney Condition (Dialysis/Shunt)

[ ]  Autoimmune Disorder

[ ]  Arthritis

[ ]  Osteoporosis/Osteopenia

[ ]  Sleep Apnea

[ ]  Cortisone/Steroid therapy

[ ]  Depression

[ ]  Anxiety

[ ]  Headaches/Migraines

[ ]  Recreational Drug Use

[ ]  Alcohol Addiction

[ ]  Seizures

[ ]  Epilepsy

[ ]  Liver Disease

[ ]  Organ Transplant

[ ]  Parkinson’s

[ ]  Alzheimer’s/Dementia

[ ]  Hyperthyroidism

[ ]  Hypothyroidism

[ ]  Ulcers

[ ]  Venereal Disease

[ ] Jaw Joint Pain

[ ]  Covid-19

**List any conditions not listed:**

**aLLERGIES & mEDICATIONS**

[ ]  **No known drug allergies**

***Mark allergy to any of the following and what reactions you’ve had.***

[ ]  Dental Anesthetic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Latex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Penicillin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Sulfa: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Erythromycin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Codeine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Metals/Jewelry:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Narcotics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Milk/Dairy Products: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Peanuts/Nuts:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] List any NOT listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***List current medications you are taking including non-prescription , herbal and vitamins:***

*\*If you have a list of medications, please give it to the front desk:*

|  |  |  |
| --- | --- | --- |
| Name of Medication | Dosage | Reason for taking |
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**BOISE PROSTHODONTICS**

**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 $25 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BOISE PROSTHODONTICS**

**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, you 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**

**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/cell, regarding appointments & financial information.

\_\_\_\_I authorize you to leave a message with anyone who answers the phone and are named above.

***Diagnostic Photos:***

\*As part of your treatment, diagnostic photos will be taken before & after completing your selected treatment plan. These photos will be utilized & shared in coordinating your treatment with your referring dentist, labs & other service providers engaged to help complete your treatment. By signing below, you authorize us to utilize your photos in connection with your treatment as outlined.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_