Dental History

Reason for today's visit:_____

_____

Former Dentist:_____

Date of last dental visit_____

Date of last dental x-rays_____

Mark "Yes " or " No" to indicate if you presently have or previously had any of the following:

Bad breath	Yes❑	No❑
Bite your lips or cheeks regularly	Yes❑	No❑
Bleeding Gums	Yes❑	No❑
Blisters on lips or mouth	Yes❑	No❑
Chew on one side of mouth	Yes❑	No❑
Dry mouth	Yes❑	No❑
Food collection between teeth	Yes❑	No❑
Grinding teeth	Yes❑	No❑
Gums swollen or tender	Yes❑	No❑
Jaw pain or tiredness	Yes❑	No❑
Mouth breathing	Yes❑	No❑
Orthodontic treatment	Yes❑	No❑
Pain around ear	Yes❑	No❑
Periodontal (gum) treatment	Yes❑	No❑
Sensitivity to cold	Yes❑	No❑
Sensitivity to hot	Yes❑	No❑

Have you experienced:

Clicking or popping of the jaw?	Yes❑	No❑
Pain? (joint, ear, side of face)	Yes❑	No❑
Dificulty in opening or closing the mouth?	Yes❑	No❑

How often do you floss?_____

How often do you brush?_____

Do you require antibiotics before dental treatment?	Yes❑	No❑
Are you currently in pain?	Yes❑	No❑
Have you ever had a serious / difficult problem associated with any previous dental work?	Yes❑	No❑
Do you like your smile?	Yes❑	No❑
Do you feel nervous about having dental treatment?	Yes❑	No❑
Have you ever had a bad experience in a dental office?	Yes❑	No❑

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know?____

_____

Medical History

Your Physical health is:

❑Good ❑Fair ❑Poor

Are you currently under the care of a physician? Yes❑ No❑

Please explain: _____

_____

Are you taking any prescription/ over the counter drugs? Yes❑ No❑

Please list each one:

_____

_____

_____

_____

_____

_____

_____

Do you smoke or use tobacco in any other forms? Yes❑ No❑

For Women:

Are you taking birth control pills?	Yes❑	No❑
Are you Pregnant?	Yes❑	No❑
Are you Nursing?	Yes❑	No❑

Do you have or have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Yes❑	No❑
Alcohol / Drug Abuse	Yes❑	No❑
Alzheimer's Disease	Yes❑	No❑
Anemia	Yes❑	No❑
Arthritis	Yes❑	No❑
Artificial Bones / Joints/Valves	Yes❑	No❑
Asthma	Yes❑	No❑
Blood Transfusion	Yes❑	No❑
Bruise Easily	Yes❑	No❑
Cancer / Chemotherapy	Yes❑	No❑
Colitis	Yes❑	No❑
Diabetes	Yes❑	No❑
Difficulty Breathing	Yes❑	No❑
Emphysema	Yes❑	No❑
Epilepsy	Yes❑	No❑
Fainting Spells	Yes❑	No❑
Frequent Headaches	Yes❑	No❑
Glaucoma	Yes❑	No❑
Hay Fever	Yes❑	No❑
Heart Problems	Yes❑	No❑
Heart Murmur	Yes❑	No❑
Hemophilia	Yes❑	No❑

Do you have or have you ever had any of the following diseases or medical problems?

Hepatitis	Yes❑	No❑
Herpes / Fever Blisters	Yes❑	No❑
High Blood Pressure	Yes❑	No❑
HIV+ / AIDS	Yes❑	No❑
Joint Replacement	Yes❑	No❑
Kidney Problems	Yes❑	No❑
Liver Disease	Yes❑	No❑
Low Blood Pressure	Yes❑	No❑
Mitral Valve Prolapse	Yes❑	No❑
Nervous/Anxious	Yes❑	No❑
Pacemaker	Yes❑	No❑
Psychiatric/Physiological Care	Yes❑	No❑
Radiation Treatment	Yes❑	No❑
Rheumatic / Scarlet Fever	Yes❑	No❑
Seizures	Yes❑	No❑
Sinus Problems	Yes❑	No❑
Stroke	Yes❑	No❑
Thyroid Problems	Yes❑	No❑
Tuberculosis (TB)	Yes❑	No❑
Tumors or Growths	Yes❑	No❑
Ulcers	Yes❑	No❑
Venereal Disease	Yes❑	No❑

Do you have or have you had any disease, condition or problem not listed above? Yes❑ No❑

If yes please describe_____

_____

Have you been hospitalized for any reason? Yes❑ No❑

If yes please describe_____

_____

Are you allergic to any of the following?

Amoxicillin	Yes❑	No❑
Aspirin	Yes❑	No❑
Clindamycin	Yes❑	No❑
Codeine	Yes❑	No❑
Dental Anesthetics	Yes❑	No❑
Erythromycin	Yes❑	No❑
Latex	Yes❑	No❑
Metals	Yes❑	No❑
Penicillin	Yes❑	No❑
Sulfa	Yes❑	No❑
Tetracycline	Yes❑	No❑

Other _____

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. I will not hold my dentist or any member of his Dental Team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature:_____ Date:_____

I certify that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient or Responsible Party Signature :_____ Date:_____

Trailridge Family Dental

Office and Financial Policy

Our philosophy is to provide the highest quality of dental care for each and every one of our patients. To reduce our administrative costs and keep our fees to you as low as possible, we ask that you pay your co-payment at the time you receive treatment.

If you have dental insurance we would be happy to file your dental claims and accept the insurance portion directly from your insurance company provided payment is received from them within 60 days. You must, however, familiarize yourself with your insurance coverage, and provide us the correct information for the submittal of your dental claims. We will provide you as close an estimate as possible for the treatment plan that is recommended for you. The insurance benefits estimate is not a guarantee of payment however. Please remember that your insurance is a contract between you, your employer, and the insurance company. Not all services are covered benefits in all contracts, therefore, you are ultimately responsible for the total amount of your dental fees.

If you are unable to keep an appointment that has been reserved for you, we require that you provide us with a 24-48 hours advance notice so that we are able to fill the opening, which you cannot keep. We realize that emergencies do occur, however and we will be flexible under those circumstances. A charge of $25 will be charged otherwise.

Please notify us of any changes related to your medical history, telephone numbers, address, employer or insurance information as it occurs. There will be a finance charge of 1.5% monthly for any unpaid balance unless other arrangements have been made.

Listed below are the methods of payment that we accept. Please identify which form of payment you intend to use to pay for your dental treatment including your co-payment.

Payment Options:

__ Cash/ Check/ Debit Card

__ Visa/ Mastercard/ American Express/ Discover

Extended Payment Options:

__ Care Credit—0% financing available

Trailridge Family Dental 205 W. Hwy 95, PO Box 420 Parma, ID 83660
trailridgefamilydental@hotmail.com
Telephone: (208)722-6400 Fax: (208)722-9016 Contact Officer: Vernena Jorgensen

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 takes effect (04/14/03), 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, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mail, text, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.15 for each page, $12.50 per hour for staff time to locate and copy your health information, and postage if you want the

copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

TRAILRIDGE FAMILY DENTAL

205 West Hwy 95 PO Box 420 Parma, ID 83660
www.trailridgefamilydental.com
e-mail: trailridgefamilydental@hotmail.com

PATIENT REGISTRATION

Name:_____ Preferred Name:_____

Address:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

How would you prefer to be contacted? ❑Home ❑Cell ❑Work ❑Text ❑Email

Social Security Number:_____ Date of Birth:_____

Employer:_____ Occupation:_____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed Gender: ❑Male ❑Female

Spouse's name:_____

Spouse's Employer:_____ Occupation:_____

Emergency Contact: Name:_____ Phone:_____ Relationship:_____

If patient is a minor, please give the parent or guardian's name:_____

Who is responsible for this account?_____

How did you hear about our office? ❑Patient Referral (Patient's Name)_____ ❑Other_____

INSURANCE INFORMATION

Subscribers Name:_____ Relationship to Patient:_____

Subscriber ID:_____ Subscriber Birth Date:_____

Insurance Co:_____ Group#:_____

Is patient covered by additional insurance? ❑Yes ❑No

Subscribers Name:_____ Relationship to Patient:_____

Subscriber ID:_____ Subscriber Birth Date:_____

Insurance Co:_____ Group#:_____

ASSIGNMENT AND RELEASE

I certify that I (or my Dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____ Date:_____