Patient Registration

First Name:_____ Last Name:_____ Middle Initial:___

Patient is: __Policy Holder __Responsible Party Preferred Name: _____

Responsible Party (if someone other than patient):

First Name:_____ Last Name:_____ Middle Initial:___

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security Number: _____ Drivers Lic: _____

Patient Information:

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Sex:: ___ MALE ___FEMALE Marital Status: ___Married ___ Single ___ Divorced ___

Birth Date: _____ Social Security Number: _____ Drivers Lic: _____

Age: _____ Email Address: _____

Who can we thank for your referral to our office? _____

Emergency Contact Information:

Name: _____

Relationship to Patient: _____

Phone Number: _____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

Are you under a physician's care now?	☐ Yes ☐ No	If yes, please explain:_____
Have you recently been hospitalized?	☐ Yes ☐ No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	Please list drugs:_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐No	
Are you on a special diet?	☐ Yes ☐No	
Do you use tobacco?	☐ Yes ☐No	
Do you use controlled substances?	☐ Yes ☐No	

Women: Are you:
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa drugs
☐ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No

Patient Dental History

Name of Previous Dentist_____ Date of Last Exam_____
Previous Dentist's Location_____ Date of Last Cleaning_____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐	14. Have you ever had any prolonged bleeding following extractions?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	15. Do you wear dentures or partials?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	If yes, date of placement_____		
4. Do you feel pain to any of your teeth?	☐	☐	16. Do you have frequent headaches?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐	17. Do you clench or grind your teeth?	☐	☐
6. History of any periodontal therapy?	☐	☐	18. Have you ever experienced any of the following problems in your jaw?		
7. Do you like your smile?	☐	☐	Clicking, popping	☐	☐
8. Do you snore or have you been told that you snore?	☐	☐	Pain (joint, ear, side of face)	☐	☐
9. Have you ever received oral hygiene instructions?	☐	☐	Difficulty in opening or closing	☐	☐
10. Have you had any head, neck or jaw injuries?	☐	☐	Difficulty in chewing	☐	☐
11. Do you bite your lips or cheeks frequently?	☐	☐			
12. Have you ever had any difficult extractions in the past?	☐	☐			
13. Have you had any orthodontic treatment?	☐	☐			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE_____

W. Scott Morrell, DDS

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature:_____

Relationship to Patient: _____

Date: _____

403 S 11th Street, Suite 200 Boise, ID 83702
208-342-3440 / Fax 208-336-4740

PAYMENT & INSURANCE POLICIES

PAYMENT POLICY

a. Patients without insurance must take care of charges in full on the day of the visit.
b. Patients with insurance must take care of all copays and estimated portinos in full on the day of the visit.
c. Patients will not be scheduled for further treatment until all balances from current work are paid in full.
d. At 45 days all patients become fully responsible for all balances owed, whether insurance has paid or not. If insurance pays after that time, you will be reimbursed for any overpayment.
e. At 60 days all outstanding balances will incur a finance charge of 1.3 % per month (16% per year) with a $5.00 minimum charge.
f. At 90 days, unpaid or delinquent balances will be referred for collection proceedings.
g. Regardless of who has financial custody of children in the event of divorce, the parent who brings the child to the office is responsible for payments of that account at the time of visit.
h. We can offer you an interest free loan through an outside credit agency if you need. Ask us for details prior to scheduling your dental work.

INSURANCE POLICY

a. The treatment we recommend may or may not agree with the provisions of your benefit package. You should always have the right to accept or deny any treatment we might recommend.
b. We do not represent, guarantee, or promise that your insurance will pay for any procedure we provide.
c. We cannot take responsibility for benefit limits, excluded services, restrictions, policy limitations, copays, deductibles, and yearly maximums that may define your plan.
d. We will do our best to estimate your insurance benefits and limits, based on industry norms. We assume no financial responsibility for the accuracy of those estimates.
e. If you have double (dual) insurance policies you must take care of all copays and estimated portions on the day of the visit, as if you had single insurance coverage. We will then file insurance forms with your secondary insurer and you will be reimbursed at the time they pay on the claim.
f. In any case, you are ultimately responsible for any and all charges, in fill, for any treatment we provide regardless of insurance.
g. Should insurance pay more than expected, any amounts overpaid will be refunded to you.

NAME: _____ Signature: _____ Date: _____

APPOINTMENT POLICY

A. We make every effort to run on schedule. If during the day, unforeseen scheduling issues arise where we fall behind, we will do our best to contact you in advance to discuss options in order to respect your time.
B. Please schedule appointment times that are most likely to work for you.
C. We understand that emergencies occasionally happen, but please give us at least 24 hours notice if you need to make a change.
D. In the event of a rescheduled appointment we do require 48 hours notice.
E. A $45 no-show / cancellation fee may be incurred without the courtesy of proper notice or in the event of a no-show.
F. After 2 no-shows / 2 cancellations without proper notice, patients will not be scheduled without prepayment of all appointment charges, which would be forfeited in the event of a no-show / cancellation for that appointment.

I have read and understand the information presented above.

NAME: _____ SIGNATURE: _____ DATE: _____