PATIENT REGISTRATION

State Street Dental Boise

Patient Information

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

Address: _____ City / Zip / State: _____

Preferred Name: _____ Referred By: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Employer / School: _____ F/T ☐ P/T ☐

Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Date of Birth: _____ Age: _____ SSN: _____ Drivers Lic: _____

Preferred Dentist: _____ Preferred Pharmacy: _____

Responsible Party (if other than patient)

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

Address: _____ City / Zip / State: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ SSN: _____ Drivers Lic: _____

Insurance Information

Primary Insurance : _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Date of Birth: _____ Date of Birth: _____

ID # or SSN: _____ ID# or SSN: _____

Employer: _____ Group #: _____ Employer: _____ Group #: _____

Emergency Contact

Emergency Contact: _____ Phone: _____

Address: _____ Relation: _____

Patient Name: _____ D.O.B. _____

State Street Dental
Boise

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Y	N	
Are you under a physician's care now?			If yes:
Have you ever been hospitalized or had a major operation?			If yes:
Have you ever had a serious head or neck injury?			If yes:
Are you taking any medications, pills, or drugs?			If yes:
Do you take, or have you taken, Phen-Fen or Redux?			If yes:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			If yes:
Are you on a special diet?			If yes:
Do you use tobacco?			If yes:

Women: Are you…

Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐

Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐

Other? ☐ If yes: _____

	Y	N	
Do you use controlled substances?			If yes:

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

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive			Cortisone Medicine			Hemophilia			Radiation Treatments		
Alzheimer's Disease			Diabetes			Hepatitis A			Recent Weight Loss		
Anaphylaxis			Drug Addiction			Hepatitis B or C			Renal Dialysis		
Anemia			Easily Winded			Herpes			Rheumatic Fever		
Angina			Emphysema			High Blood Pressure			Rheumatism		
Arthritis/Gout			Epilepsy or Seizures			High Cholesterol			Scarlet Fever		
Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Shingles		
Artificial Joint			Excessive Thirst			Hypoglycemia			Sickle Cell Disease		
Asthma			Fainting Spells/Dizziness			Irregular Heartbeat			Sinus Trouble		
Blood Disease			Frequent Cough			Kidney Problems			Spina Bifida		
Blood Transfusion			Frequent Diarrhea			Leukemia			Stomach/Intestinal Disease		
Breathing Problems			Frequent Headaches			Liver Disease			Stroke		
Bruise Easily			Genital Herpes			Low Blood Pressure			Swelling of Limbs		
Cancer			Glaucoma			Lung Disease			Thyroid Disease		
Chemotherapy			Hay Fever			Mitral Valve Prolapse			Tonsillitis		
Chest Pains			Heart Attack/Failure			Osteoporosis			Tuberculosis		
Cold Sores/Fever Blisters			Heart Murmur			Pain in Jaw Joints			Tumors or Growths		
Congenital Heart Disorder			Heart Pacemaker			Parathyroid Disease			Ulcers		
Convulsions			Heart Trouble/Disease			Psychiatric Care			Venereal Disease		

	Y	N
Have you ever had any serious illness not listed above?		

Comments:

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

X _____ Date: _____

State Street Dental
Boise

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of State Street Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations.

The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. Emerald West Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

May we phone, email or send a text to you to confirm your appointments? ☐ **Yes** ☐ **No**

May we leave a message on your answering machine at home or on your cellphone? ☐ **Yes** ☐ **No**

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family ☐ **Yes** ☐ **No**

Spouse Only ☐ **Yes** ☐ **No**

Other (please specify): _____ ☐ **Yes** ☐ **No**

_____	_____
Printed Name of Patient	Signature of patient or guardian
_____	_____
Date	Relationship to Patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgment
☐ Other – please specify_____

State Street Dental
Boise
5993 W State St., Suite B • Boise, ID • 83703 • (208) 939-1700

PLEASE READ AND INITIAL EACH LINE THEN SIGN AND DATE AT THE END

State Street Dental Financial Policy

APPOINTMENTS
We will do our best to schedule your appointment at a convenient time. A 24 hour notice is requested if you are unable to keep your scheduled appointment. Appointments are confirmed by phone, text or email whenever possible. If we are unable to reach you, we trust that you will keep your appointment. A cancellation fee of $75.00 may be applied for repeated short notice cancellations. _____

INSURANCE
We must emphasize that our relationship is with you, not your insurance company. We file the claim as a courtesy to our patients, but all charges are your responsibility from the date the services are rendered. ***All insurance estimates are exactly that – only an estimate.*** Not every service is a covered benefit in all contracts. The insurance companies have their own fee schedules and they make their payments based on that. There may also be waiting periods and time limitations placed on certain services. It is important that you read and understand your dental insurance policy and its requirements for coverage. We currently send claims to over 1000 plans and are not responsible for knowing the requirements of your specific plan. All deductibles and co-payments are due at time of service. _____

FINANCIAL
Payments are due at the time treatment is provided. We accept cash, checks, Visa, MasterCard, Discover and American Express. We also offer Care Credit if you need to make payments. You may contact Care Credit at www.carecredit.com or we can have you approved in the office. Any balance older than 90 days is subject to finance charges of 1.5% per month (18% per annum).

Financing through Wells Fargo and Key bank are also available. Please call us for additional details. _____

PAST DUE BALANCES & DELINQUENT ACCOUNTS
A past due balance is any amount owing from a prior visit, where insurance is not pending or an insurance payment is not received by us within 90 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at the time of service.

In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees.

_____

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance on my account for any professional services received. I have read the above information and agree to the above stated policy, and have received a copy of said policy.

_____ _____
Signature of Patient or Responsible Party Printed Name

Date: _____

State Street Dental
Boise

DATE: _____

Name:		Employer:	
Whom may we thank for this referral:			

Are you having any specific problems? Problem began when?	
Do you have any teeth that are sensitive to hot or cold? Sweet? Hurt when you chew? Ache without any apparent reason?	
How long since your last thorough dental examination?	
Were you screened for Periodontal disease or oral cancer?	
Is there anything concerning your general health or past dental treatment that you would like to tell us about?	
Do your gums ever hurt or bleed when brushing?	
Do you have any areas where food always gets caught between your teeth?	
Are you troubled with bad tastes in your mouth or bad breath?	
Do you use dental floss regularly to clean between your teeth?	
Have you lost any other teeth than your wisdom teeth? Were they replaced? Has it ever been suggested to you? What type of replacement?	
Is there anything you would change about the appearance of your teeth or smile?	

State Street Dental
Boise

5993 W State St., Ste. B Boise, ID 83703
(208) 939-1700 Phone / (208) 939-9253 Fax
statetstreetdentalboiseid@gmail.com to email records

AUTHORIZATION TO RELEASE CONFIDENTIAL DENTAL INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone Number _____

City _____ State _____ Zip _____

I hereby request that you release a copy or summary of my dental records, including x-rays and reports that you have which may contain information relevant to my present and future dental treatment. Thank you.

Office authorized to release dental records:

Name of Office _____

Name of Dentist _____

Address _____

City,ST Zip _____

Phone _____ Fax _____

Email _____

Who they are authorized to release records to

State Street Dental
Name of Office

Chad D. Hess, D.D.S. / Greg Davis, D.D.S.
Name of Dentist

5993 W State St., Ste. B
Address

Boise, ID 83703
City,ST Zip

(208) 939-1700 (208) 939-9253
Phone Fax

statestreetdentalboiseid@gmail.com
Email

I understand that I do not have to sign this authorization to receive dental care; however, I do have to sign an authorization form to give my permission for my records to be released to another party.

Patient or Legal Guardian _____ Date _____

Printed Name if Signed by Guardian _____ Relationship _____

Office Use Only: Date: _____ Contact: _____ Date of X-rays: __/__/____ BW __/__/____ PANO
Notes: