Welcome!

Preston Dental Care
135 S. State St.
Preston ID 83263
Phone: (208) 852 - 3700
Fax: (208) 852 - 3777

It is a pleasure to serve you! Please fill out the forms completely. If you have any questions, please ask.

ABOUT YOU 1

Today's Date_____/_____/_____ **Patient Name:**_____
Last **First** **M**

What You Prefer To Be Called:_____ ☐ Male ☐ Female Birthdate:_____/_____/_____ Age:_____

SS#:_____ Mailing Address:_____

_____

CITY STATE ZIP

Home Phone#: (____)_____W. Ph:(____)_____ Cell Ph(____)_____E-Mail: _____

Referred By:_____ **Employer:**_____

Employer's Address:_____

Occupation:_____Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widow(er)

Spouse's Name_____

_

MEDICAL HISTORY 2

Are you taking any of the following medications?
☐Nerve pills ☐Pain killers (including aspirin) ☐Muscle relaxers ☐Stimulants ☐Blood Thinners ☐Tranquilizers ☐Insulin

Do you have or have you had any of the following diseases, medical conditions or procedure?

☐Alcohol/Drug abuse	☐Cosmetic Surgery	☐Heart Murmur	☐Radiation Treatment
☐Allergies	☐Diabetes/Hypoglycemia	☐Heart Surgery/Pacemaker	☐Respiratory Problems
☐Arthritis	☐Difficulty Breathing	☐Hepatitis	☐Rheumatic Fever
☐Artificial Bones/Joints	☐Emphysema	☐High/Low Blood Pressure	☐Scarlet Fever
☐Artificial Valves	☐Excessive Bleeding	☐HIV/AIDS/ARC	☐Severe Frequent Headaches
☐Asthma	☐Fainting/Seizures/Epilepsy	☐Jaw Problems/TMD	☐Shingles
☐Back Problems	☐Frequent Neck Pain	☐Kidney Disease	☐Sinus Problems
☐Cancer/Tumors	☐Glaucoma	☐Leukemia	☐Stomach Problems/Ulcers
☐Chemotherapy	☐Head Injuries	☐Liver Disease	☐Thyroid Problems
☐Chest Pains	☐Heart Attack/Stroke	☐Mitral Valve Prolapse	☐Tuberculosis
☐Congenital Heart Defect	☐Heart Disease	☐Nervous Disorders	☐Venereal Disease

Current Medications (list):
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Are you allergic to any of the following? ☐Latex ☐Penicillin/Amoxicillin ☐Tetracycline ☐Aspirin
☐Dental Anesthetics ☐Others: _____

Do you use tobacco? ☐No ☐Yes/How used?_____How Much?_____How Long?_____

Have you ever taken the drug Phen-fen and/or Redux? ☐Yes ☐No

For Women: **Are you taking Birth Control pills?** ☐Yes ☐No

How many children have you had?_____

Are you Pregnant? ☐No ☐Yes/How long?_____

Are you nursing? ☐Yes ☐No

ACCOUNT INFO 3

Person Ultimately Responsible for Account

Name:_____

Relation:_____

Billing Address:_____

_____

CITY STATE ZIP

SS#:_____Wk Ph #(____)_____

Payment Method: ☐ Cash ☐ Check ☐ CC

_____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

INSURANCE INFO 4

PRIMARY DENTAL INSURANCE

Co. Name: _____

Address:_____

_____

CITY STATE ZIP

Phone#:(____)_____Ins. ID#:_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____

Relation:_____DOB:____/_____/_____

Insured's Employer:_____

SECONDARY DENTAL INSURANCE

Co. Name:_____

Address:_____

_____

CITY STATE ZIP

Phone#: (____)_____Ins ID#:_____

Insured's Name:_____

Group # (Plan, Local, or Policy #)_____

Insured's Name:_____

Relation:_____DOB_____

Insured's Employer_____

DENTAL INFORMATION 5

Reason for today's visit: ☐Exam ☐Emergency ☐Consultation

Are you in pain? ☐No ☐Yes How Long?_____

Please Indicate any of the following problems:

- ☐ Discomfort, clicking or popping in jaw
- ☐ Red, swollen or bleeding gums.
- ☐ Sensitive tooth, teeth or gums
- ☐ Blisters/Sores in or around the mouth
- ☐ Stained teeth
- ☐ Bad Breath
- ☐ Lost/Broken Filling(s)
- ☐ Teeth grinding
- ☐ Ringing in Ears
- ☐ Broken/Chipped tooth
- ☐ Locking Jaw
- ☐ Other:

Do you require premedication? ☐ Yes ☐ No ☐ Don't know

Last Dental Exam: ____/_____/_____

Last Dental X-Rays:_____/_____/_____

Times a day you brush? _____

Times a week you floss?_____

How would you rate your smile?

(worst) 1 2 3 4 5 6 7 8 9 10 (Best)

IN EVENT OF EMERGENCY 6

Whom should we contact?_____

Relation:_____

Home Phone #: (____)_____

Work Phone #: (____)_____

Cell Phone #: (_____)_____

Who is your Medical Doctor?_____

Medical Doctor's Phone #:(____)_____

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 60 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ _Date_____/_____/_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Preston Dental Care Kurt O. Iverson, DDS Family Dentistry

FINANCIAL POLICY

The treatment estimate sheet is provided for your convenience in planning your family's dental treatment. Feel free to discuss any questions you may have with our staff. The costs listed are an estimate only and may need to be revised if changes occur in your dental health or that of your family members. *Estimated costs are valid for treatment completed within 90 days of the date of estimate.*

PAYMENT OPTIONS

Our mission is to deliver the finest, most effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the cost of today's and future treatments.

Payment is due at time of treatment for all visits unless prior arrangements have been made.. We are sensitive to the fact that some people may not be able to pay cash for their treatment, therefore, we offer several alternative payment programs for your convenience.

- **Cash or Check (8% discount when paid at time of treatment)**
- **MasterCard or Visa (5% discount when paid at time of treatment)**
- **Care Credit**

Please indicate below the form of payment you wish to choose to settle your account:

[ ] Prepayment
[ ] Cash or Check
[ ] Visa or MasterCard
[ ] Care Credit Account

FINANCIAL AGREEMENT

In accordance with the Federal Truth-in Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which may apply in this office. The responsible party agrees to:

- Pay the doctor at the time service is rendered or by previous arrangements
- As we are trying to meet the needs of so many patients we ask that you give us 24 hours notice prior to your appointment in the unlikely event you may need to reschedule your appointment. A $30 fee may be assessed when 24 hours notice is not given. If more than 3 appointments are missed with less than 24 hours notice you may be dismissed from the practice.
- That if payments are extended beyond 60 days from the date of service, you pay 1.5% month on the unpaid balance (annual rate of 18%). I/We further agree to pay for all legal fees and collection costs reasonably incurred in connection therewith, interest not paid when due shall be added to and become part of the principal.
- We are more than happy to assist you in filing your insurance claims. However, all charges incurred are the financial responsibility of the undersigned (patient, parent, or guardian) regardless of insurance coverage. In the event your insurance company does not cover the entire balance of this account within 45 days from the date of service, **I agree to pay the balance in full.**
- Personal credit may be checked.
- We offer an 8% discount for cash payment on the date of service

Today's Date_____

Responsible Party:_____

Preston Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received the opportunity to review a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

_____

_____

_____