

WATER'S EDGE DENTAL

PATIENT INFORMATION

Patient's Name _____ Today's Date ____/____/_____
 Birth Date ____/____/____ Age _____ SSN ____/____/_____
 Marital Status Single Married Divorced Widowed Separated
 Home Address _____ Phone (H) (____) _____ - _____
 City/State/ZIP _____ (C) (____) _____ - _____
 E-mail address _____
 Please send me appointment reminders via: text email

Employer _____ **Occupation** _____
 Business Address _____ Phone (____) _____ - _____
 City/State/ZIP _____

Spouse/Partner Name _____ **Spouse/Partner Employer** _____
 Address _____
 City/State/ZIP _____ Phone # (H) _____ (C) _____

Person Responsible for Account: Self Spouse/Partner Parent
 Other (please specify) _____

Contact in case of dental emergency: _____
 Address _____
 City/State/ZIP _____ Phone # (H) _____ (C) _____

Whom may we thank for referring you: _____

If Patient Is A Minor: I hereby grant permission for dental work to be performed on this minor and will assume all responsibilities connected with such treatment.

Signature of Parent or Guardian _____

DENTAL HISTORY

Reason for Today's Visit _____

Please Check (☑)	Yes / No	Yes/No	Yes/No
Sensitivity to hot/cold	<input type="checkbox"/> <input type="checkbox"/>	Cigarette/pipe/smoking	<input type="checkbox"/> <input type="checkbox"/>
Gum disease	<input type="checkbox"/> <input type="checkbox"/>	(__ yrs.)	<input type="checkbox"/> <input type="checkbox"/>
Sore on lips or in mouth	<input type="checkbox"/> <input type="checkbox"/>	Chew tobacco	<input type="checkbox"/> <input type="checkbox"/>
Dry mouth	<input type="checkbox"/> <input type="checkbox"/>	Chew on one side only	<input type="checkbox"/> <input type="checkbox"/>
Bleeding gums	<input type="checkbox"/> <input type="checkbox"/>	Grinding teeth	<input type="checkbox"/> <input type="checkbox"/>
Jaw pain	<input type="checkbox"/> <input type="checkbox"/>	Mouth breathing	<input type="checkbox"/> <input type="checkbox"/>
Discolored teeth	<input type="checkbox"/> <input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/> <input type="checkbox"/>
		Crowded teeth	<input type="checkbox"/> <input type="checkbox"/>
		Bad breath	<input type="checkbox"/> <input type="checkbox"/>
		Food collection	<input type="checkbox"/> <input type="checkbox"/>
		Swelling around teeth	<input type="checkbox"/> <input type="checkbox"/>
		Broken fillings	<input type="checkbox"/> <input type="checkbox"/>
		Loose teeth	<input type="checkbox"/> <input type="checkbox"/>
		Braces	<input type="checkbox"/> <input type="checkbox"/>

Are you interested in: bleaching? veneer? straighter teeth?

What would you change about your smile? _____

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MEDICAL HISTORY

Name (please print) _____

Name of primary medical provider (physician): _____ phone # _____

Are you taking medication at this time? Yes No

If so, please list and provide dosage. _____

Are you allergic to: Penicillin Codeine Dental anesthetic Metals/other materials?

Are you susceptible to latex allergies? Yes No

Do you have any other allergies we should be aware of? _____

Are you pregnant or think you are pregnant? Yes No Estimated due date: ___/___/_____

Are you subject to prolonged bleeding fainting spells excessive urination or thirst

Have you ever had any type of radiation therapy (other than diagnostic)? Yes No

Please Check (☑)	Yes / No		Yes / No
Abnormal blood pressure	<input type="checkbox"/> <input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/> <input type="checkbox"/>
Arthritis or Rheumatism	<input type="checkbox"/> <input type="checkbox"/>	Mitral valve prolapsed	<input type="checkbox"/> <input type="checkbox"/>
Artificial joints	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis	<input type="checkbox"/> <input type="checkbox"/>
Date of surgery: ___/___/_____		HIV/AIDS	<input type="checkbox"/> <input type="checkbox"/>
Asthma or hay fever	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>
Blood disease or anemia	<input type="checkbox"/> <input type="checkbox"/>	Kidney disorder	<input type="checkbox"/> <input type="checkbox"/>
Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>	Leukemia	<input type="checkbox"/> <input type="checkbox"/>
Chronic cough	<input type="checkbox"/> <input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/> <input type="checkbox"/>
Cold sores or fever blisters	<input type="checkbox"/> <input type="checkbox"/>	Parkinson's	<input type="checkbox"/> <input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/>
Epilepsy	<input type="checkbox"/> <input type="checkbox"/>	Sinus trouble	<input type="checkbox"/> <input type="checkbox"/>
Frequent canker sores	<input type="checkbox"/> <input type="checkbox"/>	STDs	<input type="checkbox"/> <input type="checkbox"/>
Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>
Head injury	<input type="checkbox"/> <input type="checkbox"/>	Thyroid condition	<input type="checkbox"/> <input type="checkbox"/>
Heart disease	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis or lung disease	<input type="checkbox"/> <input type="checkbox"/>
Heart murmur	<input type="checkbox"/> <input type="checkbox"/>	Tumors or growths	<input type="checkbox"/> <input type="checkbox"/>
		Ulcers	<input type="checkbox"/> <input type="checkbox"/>

Any other medical problems we need to be aware of: _____

Signature _____

Date ___/___/_____

WATER'S EDGE DENTAL

Geoffrey P. Herzog, DMD, FAGD

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to Water's Edge Dental. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. All charges you incur are your responsibility regardless of your insurance coverage. If your treatment requires the use of a dental lab (crowns, bridges, partials, dentures, etc.) **50%** of your estimated fee **IS REQUIRED** on your first treatment appointment. Water's Edge Dental offers a 5% discount on services paid in full at time of service (for non-insured, cash/check paying patients). For services exceeding \$750.00 a payment plan will be required prior to the start of the dental treatment.

Dental Insurance: As a courtesy to you, we will be happy to complete and forward insurance forms relative to your dental treatment, and will do so at no charge. To serve and assist you in utilizing your dental insurance, Water's Edge Dental accepts assignment of benefits from your insurance company. It is your responsibility to provide us with the correct subscriber ID number and the correct mailing address of your insurance carrier. Please keep in mind that our professional treatment is rendered to you, NOT your insurance company. Therefore, ultimate responsibility for payment is yours. The determination of what benefits are allowed is a negotiation between your employer and the insurance provider. If you have any questions about the amount the insurance plan will pay or the treatments your plan will cover, you should refer these questions to your employer. At your request, this office will provide all pertinent information to your insurance company and we will do our best to help you derive the maximum benefits available.

Your *estimated* co-payment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Our practice accepts cash, personal checks, MasterCard, VISA and Discover. We also accept CareCredit and Wells Fargo Health Advantage Plan. Please ask us if you would like more information regarding these programs.

Returned checks, bank fees and balances older than 90 days will be subject to finance charges at the rate of 1.5% per month (18% annually).

I acknowledge and agree that I may be required to pay a missed appointment fee if I have missed two or more appointments in the last twelve months. A missed appointment is considered to be one that I do not keep or do not cancel within 48 hours of its scheduled time.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

Print Name of Patient or Responsible Party

Signature of Patient or Responsible Party

Date ____/____/____

WATER'S EDGE DENTAL

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified on your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, good, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request the change in certain policies used within the office concerning our PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Print name of Patient or Responsible Party

Signature of Patient or Responsible Party

Date _____ / _____ / _____

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Geoffrey P. Herzog, DMD, FAGD

PROTECTED HEALTH INFORMATION RELEASE

(Patients 18 years and older)

Please check all applicable spaces and fill in any blank spaces where information is requested.

Patient Name _____ DOB _____

_____ Only release information to me personally (unless marked below)

_____ You have my authorization to speak with my spouse/significant other about my dental care:

Spouse/ Significant Other's Name _____ Phone _____

_____ I authorize you to speak with my adult family members or other individuals about my dental care as identified here:

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

_____ You have my authorization to leave information on my voicemail regarding my dental care.

_____ Other, please describe: _____

Signature of Patient or Responsible Party

Date ____/____/____

WATER'S EDGE DENTAL

Geoffrey P. Herzog, DMD, FAGD

REQUEST FOR DENTAL RECORDS

Patient's Name: _____
Last Name First Name Middle

Date of Birth

I hereby request and authorize:

Previous dental office: _____

City: _____ State: _____

E-mail contact: _____

Phone: _____ Fax: _____

To be released to:

Water's Edge Dental
6657 N Glenwood
Boise, ID 83714

**** Records may be emailed to: frontoffice1@wedboise.com ****

Date of most recent: panoramic _____ bitewings _____ FMX _____

Has patient had periodontal treatment in your office? YES _____ NO _____

If so, please specify type and date(s) of treatment:

I acknowledge that data to be released **MAY INCLUDE** material that is protected by Federal Law and that is applicable to **ANY & ALL** of the above.

My signature below authorizes release of all such information.

Signature of Patient or Responsible Party

Date