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	☐☐	Cigarette/pipe/smoking (___ yrs.)	☐☐	Crowded teeth	☐☐
Gum disease	☐☐			Bad breath	☐☐
Sore on lips or in mouth	☐☐	Chew tobacco	☐☐	Food collection	☐☐
Dry mouth	☐☐	Chew on one side only	☐☐	Swelling around teeth	☐☐
Bleeding gums	☐☐	Grinding teeth	☐☐	Broken fillings	☐☐
Jaw pain	☐☐	Mouth breathing	☐☐	Loose teeth	☐☐
Discolored teeth	☐☐	Lip or cheek biting	☐☐	Braces	☐☐

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	☐	☐	Heart pacemaker	☐	☐
Arthritis or Rheumatism	☐	☐	Mitral valve prolapsed	☐	☐
Artificial joints	☐	☐	Hepatitis	☐	☐
Date of surgery: ___/___/_____			HIV/AIDS	☐	☐
Asthma or hay fever	☐	☐	Jaundice	☐	☐
Blood disease or anemia	☐	☐	Kidney disorder	☐	☐
Chemotherapy	☐	☐	Leukemia	☐	☐
Chronic cough	☐	☐	Multiple sclerosis	☐	☐
Cold sores or fever blisters	☐	☐	Parkinson's	☐	☐
Congenital heart lesions	☐	☐	Psychiatric treatment	☐	☐
Diabetes	☐	☐	Rheumatic fever	☐	☐
Epilepsy	☐	☐	Sinus trouble	☐	☐
Frequent canker cores	☐	☐	STDs	☐	☐
Glaucoma	☐	☐	Stroke	☐	☐
Head injury	☐	☐	Thyroid condition	☐	☐
Heart disease	☐	☐	Tuberculosis or lung disease	☐	☐
Heart murmur	☐	☐	Tumors or growths	☐	☐
			Ulcers	☐	☐

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

Signature_____ Date _____/_____/_____

WATER'S EDGE DENTAL

Geoffrey P. Herzog, DMD, FAGD
Allie R. Hyder, DDS

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 polices:

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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Allie R. Hyder, DDS

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: _____

_____ Date _____/_____/_____

Signature of Patient or Responsible Party

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Allie R. Hyder, DDS

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:** backoffice@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