PATIENT REGISTRATION

Date:_____ Date of Birth: _____

Patient Name_____ SS #:_____

☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address Street:_____

City: _____ State: _____ Zip: _____

Phone Numbers Home: ( ) _____ Business: ( ) _____

Mobile: ( )_____ Email: _____

Employer _____

If patient is a minor, who is legally responsible? _____

SS#_____ DOB _____

In case of emergency, who should we contact? _____

Phone: ( ) _____ Relationship: _____

Referred by: _____

Method of Payment: ☐ Cash ☐ Check ☐ Visa or Mastercard

INSURANCE INFORMATION

Is treatment covered by insurance? ☐ Yes ☐ No

Name of Insurance Company_____ Phone:( )_____

Insurance Address:_____

Subscriber's Name: _____ SS#: _____

Date of Birth: _____ Patient's Relationship to Subscriber:_____

Subscriber's Employer:_____ Group or Policy Number: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Name of Secondary Insurance Company _____ Phone: ( )_____

Insurance Address:_____

Subscriber's Name: _____ SS#: _____

Date of Birth::_____ Patient's Relationship to Subscriber:_____

Subscriber's Employer:_____ Group or Policy Number: _____

I hereby authorize payment of the dental and insurance benefits and authorize the release of dental information to my insurance company in order for claims to be processed. I have received the financial agreement for insurance.

_____

Patient or Guardian Signature

PATIENT MEDICAL HISTORY

Patient Name (please print) _____
Physician _____ Office Phone_____ Date of Last Physical Exam _____
Are you under medical treatment now?_____ Have you been in the last 2 years? _____
Have you ever been hospitalized for any surgery or serious illness? _____When_____
Do you have or have you had any of the following conditions? **PLEASE CHECK ALL THAT APPLY.**

___Arthritis
___Asthma/Respiratory
___Bulimia/Anoxia
___Cancer
___Chest Pains
___Diabetes
___Epilepsy/Convulsions
___Fainting
___Hay Fever/Allergies
___Hepatitis/Jaundice
___High___Low Blood Pressure
___Heart Attack/Surgery
___Heart Murmur
___Heart Disease/pacemaker
___Herpes Simplex I or II
___HIV Infection/Aids
___Kidney Disease
___Leukemia/Anemia/Blood disorder
___Glaucoma
___Take Bisphosphonates (e.g. Fosamax, Boniva, Actenol)
___Full/partial Joint Replacement Date of joint replacement/s_____
___I have taken Fen-Phen
___Radiation/Chemotherapy
___Recreational Drug use
___Rheumatic Fever
___Stomach Problems
___Stroke
___Thyroid Problems
___Tuberculosis
___Wear contacts

Anything not mentioned above_____

Women only: Are you pregnant?_____ Are you taking birth control? _____
Are you aware that antibiotics can decrease the effectiveness of birth control? _____

MEDICATIONS

Please list medications you are currently taking:

_____
_____
_____
____ Not currently taking medication
Pharmacy Name: _____

ALLERGIES

Have you had a reaction to any of the following?
(Please check if yes)

Aspirin/Ibuprofen____ Penicillin____
Codeine____ Sedatives____
Iodine ____ Sulfa____
Latex___ Local Anesthetic____
No known drug allergies____ Other _____

PATIENT DENTAL HISTORY

When was your last dental visit? _____ For what reason? _____
Who was your previous dentist? _____ When were x-rays last taken? _____

Yes	No		Yes	No	
____	____	Are you having pain/discomfort at this time?	____	____	Have you had any problems with your jaw?
____	____	Do your gums bleed when you brush?	____	____	Do you clench or grind your teeth?
____	____	Do you have a history of gum disease?	____	____	Do you wear a denture, partial or retainer?
____	____	Have you had difficult extractions in the past?	____	____	Have you had a bad dental experience?
____	____	Do you have any lumps in/near your mouth?	____	____	Do you use tobacco products? Pack/day_____
____	____	Have you had any head, neck or jaw injuries?	____	____	Do you like your SMILE?

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information may be detrimental to my health.

Patient Signature_____ Parent or Guardian_____

Date_____

FINANCIAL ARRANGEMENTS, DENTAL INSURANCE AND APPOINTMENT POLICIES

Financial Arrangements

We ask that you **be prepared to make full payment** for dental services on the day they are rendered unless you have made prior arrangements with us in advance of your appointment. For your convenience we accept cash, Mastercard, Visa, American Express and Discover Card. We also offer a prepayment option for those interested. Please ask us about the details.

Dental Insurance

We will be happy to process your dental claim for you, however we must emphasize to you that our relationship as dental care providers is with you, the patient, not with your insurance company. While we do file the claim as a courtesy to you, **all charges are your responsibility from the date that they are provided.** We will also do our best to estimate as closely as possible the amount of your treatment plan that your company will cover. You must understand that this is only an estimate, not a guarantee of coverage. We encourage you to become familiar with your own policy as it is virtually impossible for us to know the details of the many different policies presented to us by our patients.

Returned checks will be subject to additional collection fees and balances over 60 days will be subject to monthly interest charges.

Before beginning your treatment, we will gladly discuss with you your proposed treatment plan and the associated fees. We are happy to answer any questions that you may have.

Appointments

Please give us 24 hours notice if you are unable to keep your appointment, otherwise you may be charged a **$25 fee for missed appointments.** We also reserve the right to terminate our relationship with you as your dental health care provider due to continued missed/canceled appointments. We do not double-book your appointments, the time is set aside for you and we count on you keeping your appointments.

If you have any questions about our policies, or any uncertainty about your insurance coverage, please do not hesitate to ask us and we will do all that we can to assist you.

I have read and understand the above policies and am willing to abide by them.

Patient Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

RIVERVIEW DENTAL

Dr. Quinn Brown – 1175 E Parkcenter Blvd #101 Boise, ID 83706

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed. It also explains how to obtain access to this information. Please review it carefully.

The Health Information Portability and Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of the health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization reviews. For example, we disclose treatment information when billing insurance for your treatment.
Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending postcards and/or leaving messages at home/work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Office at the practice address listed below.
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless y you agree in writing to remove it. The right to request to received confidential communications of protected health information from us by alternative or at alternative locations. The right to access, inspect, and copy your protected health information. You have the right to request an amendment to your protected health information. The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 15, 2003** and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revises Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact: For more information about HIPPA or to file a complaint:

Quinn A. Brown, D.M.D.
1175 E Parkcenter Blvd. #101
Boise, Id 83706

US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, DC 20201
(877)696-6775 (toll free)

PATIENT SIGNATURE_____ **Date:**_____