RIVERVIEW DENTAL

Patient Registration

Date:_____ Date of Birth:_____

Patient Name:_____ SS#:_____

Preferred Name: _____ ▢ Male ▢ Female

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

Home Address: Street:_____

City: _____ State:_____ Zip:_____

Phone Numbers: Home:_____

Mobile:_____

Email:_____

Employer:_____

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

SS#:_____ DOB:_____

In case of an emergency, who should we contact? _____

Phone:_____ Relationship:_____

Referred by:_____

Insurance Information

Is treatment covered by insurance? ▢ Yes ▢ No

Name of insurance company:_____ Phone:_____

Insurance address:_____

Subscriber name:_____ SS#:_____

Date of Birth:_____ Patients relationship to subscriber:_____

Subscribers Employer:_____

Policy#:_____ Group#:_____

Is the patient covered by additional insurance?: ▢ Yes ▢ No

Name of Secondary Ins Company: _____

Subscriber name:_____ SS#:_____

Date of Birth:_____ Patients relationship to subscriber:_____

Subscribers Employer:_____

Policy#:_____ Group#:_____

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.

Patient or Guardian Signature:_____

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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? ▢ Yes ▢ No
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	_____Heart Attack/Surgery	_____Asthma/Respiratory
_____Heart Murmur	_____Recreational Drug use	_____Bulimia/Anoxia
_____Heart Disease/pacemaker	_____Rheumatic Fever	_____Cancer/Leukemia
_____Herpes Simplex I or I	_____Stomach Problems	_____Chest Pains
_____HIV Infection/Aids	_____Stroke	_____Thyroid Problems
_____Diabetes	_____Kidney Disease	_____Epilepsy/Convulsions
_____Anemia/Blood	_____Tuberculosis	_____Wear contacts
_____Fainting	_____Hay Fever/Allergies	_____Hepatitis/Jaundice
_____Heart Valve replacement	_____Low/High Blood Pressure	_____Glaucoma
_____Take Bisphosphonates(e.g. Fosamax, Boniva, Actenol)		_____Full/partial Joint
Replacement	_____Date of joint replacement/s	_____I have taken Fen-Phen

Anything not mentioned above_____

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

Medications

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

Allergies

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

Aspirin/Ibuprofen_____ Penicillin_____
Codein_____ 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 in 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 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?
_____	_____	Have you had any 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 answered accurately. I understand that providing incorrect information may be detrimental to my health.

Patient Signature:_____ Parent or Guardian:_____

RIVERVIEW DENTAL

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 (HIPAA) 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. HIPAA provides penalties for covered entities that misuse personal information. As required by HIPAA, 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 Office at the practice address listed above.

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 you agree in writing to remove it. The right to request to receive 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:_____

RIVERVIEW DENTAL

Financial Arrangements, Dental Insurance and 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. Please ask for a treatment plan with expected co-pay before you schedule your next appointment. We make every effort to bill your insurance as a courtesy to you, but that does not guarantee benefits. It is important that you understand the financial responsibility belongs to the patient receiving treatment.
We accept cash, check, credit card, Care Credit for special financing, and a 90 day payment plan with auto pay.

Appointment Cancellation Guidelines

We respect the value of your time, except for unforeseen emergency situations, you can expect us to be on time for your appointment. We expect the same courtesy.

Appointment cancellations with less than 48 hours notice, will be subject to a $50.00 cancellation fee. There is no charge for rescheduling with at least 48 hours notice. We understand that valid emergencies do arise, and in certain unforeseen circumstances we are happy to waive this fee.

Please help us in our continued efforts to provide our patients with quality service.
We value your patronage.

Patient Name:_____

Patient Signature: _____

Date: _____