

# Premier Dentistry of Eagle

Shane S. Porter, DMD

## Patient Information

Today's Date: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_  Male  Female \_\_\_\_\_  
Last First Mi Mr Mrs Ms Dr Name I Prefer

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Social Security #: \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated

**Home Address:** \_\_\_\_\_  
Street City State Zip

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell/Other #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Employer: \_\_\_\_\_ Length of Employment? \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Other family members seen by us: \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

## Person Responsible For Account (Parent, Guardian, Etc...)

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street City State Zip

## Spouse Information

His/Her Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

## Dental Insurance Information

### Primary Insurance

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street/PO Box City State Zip

Policy Holder's Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ Relation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Street/PO Box City State Zip

### Secondary Insurance

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street/PO Box City State Zip

Policy Holder's Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ Relation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Street/PO Box City State Zip

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you maintain and reach maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## Medical History

Name of primary physician: . . . . . \_\_\_\_\_

Have you ever been hospitalized or had a major operation? . . .  Yes  No \_\_\_\_\_

Have you ever had a serious head or neck injury? . . . . .  Yes  No \_\_\_\_\_

List medications, pills, or drugs you are currently taking? . . . . . \_\_\_\_\_

Do you take or have you ever taken Phen-Fen, or Redux? . . . . .  Yes  No \_\_\_\_\_

Do you take Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? . . . . .  Yes  No \_\_\_\_\_

Are you on a special diet? . . . . .  Yes  No \_\_\_\_\_

Do you use tobacco? . . . . .  Yes  No \_\_\_\_\_

Do you use controlled substances? . . . . .  Yes  No \_\_\_\_\_

**Women:** Are you Pregnant?  Yes  No Due Date \_\_\_\_\_ Trying to get pregnant?  Yes  No

Nursing?  Yes  No Taking oral contraceptives?  Yes  No

**Are you allergic to any of the following:**

Aspirin  Yes  No Penicillin  Yes  No Codeine  Yes  No Acrylic  Yes  No Metal  Yes  No

LateX  Yes  No Local Anesthetics  Yes  No Sulfa drugs  Yes  No Other  Yes  No \_\_\_\_\_

**Have you experienced the following:**

Aids/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis-Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Have you ever had any serious illness not listed above?  Yes  No  N/A \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Dental History

Do you like your smile? . . . . .  Yes  No \_\_\_\_\_

Are you currently in pain? . . . . .  Yes  No \_\_\_\_\_

Do you require antibiotics before dental work? . . . . .  Yes  No \_\_\_\_\_

Do your gums ever bleed? . . . . .  Yes  No \_\_\_\_\_

Have you ever experienced pain/discomfort in your jaw joint? . . . . .  Yes  No \_\_\_\_\_

Do you snore? . . . . .  Yes  No \_\_\_\_\_

I understand the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of Patient, Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

## **FINANCIAL POLICY**

This is an agreement between Premier Dentistry of Eagle and the patient. By executing this agreement, you are agreeing to pay for all services that are received.

**Payments:** Payment for service is expected at time of service unless other arrangements have been approved prior to your appointment. Accounts are considered past due if not paid by the 15<sup>th</sup> of each month.

**Payment options:**

- A. You may pay your portion at time of service by cash, check, Visa, MasterCard, Discover, American Express or accepted credit option.
- B. Regarding extensive treatment (crowns, bridges, etc), you may pay 50% of your portion on the preparation date and the balance prior to delivery.

**Finance charge:** A finance charge may be imposed on each item of your account which has not been paid within thirty (30) days. The finance charge will be computed at the rate of one and one-half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE of 18%. The minimum finance fee is \$2.50.

**Late fee:** A late fee of \$25.00 will be assessed on all charges that are not paid in full by the 15<sup>th</sup> of each billing cycle.

**Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we will estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **By agreeing to treatment you agree and understand that you are responsible for benefits, payments or any claim inquiries including yearly maximums.**

**Returned checks:** There is a fee (currently \$30.00) for any checks returned by the bank.

**Missed appointment fee:** We require at least 24 hour notice in order to change any appointments. Appointments that are missed and/or cancelled with less than 24 hour notice may be subject to a \$75.00 fee per hour of scheduled treatment time.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection costs incurred. If we have to refer collection of the balance to an attorney, you agree to pay all associated attorney fees including court costs. In case of suit, the venue shall be in Ada County.

**Waiver of confidentiality:** If your account is referred to a collection agency or an attorney or if we have to litigate in court, the fact that you received treatment in office will become matter of public record.

**Divorce:** In case of separation or divorce, the party responsible for the account prior to the separation or divorce shall remain responsible for the account. After separation or divorce, the parent authorizing treatment for the minor will be responsible for payment. If the divorce decree requires the other parent to pay part or all of the treatment costs it is the authorizing parent's responsibility to collect from the other parent.

**Checks:** When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. For inquiries, please call 208-938-1247. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make payment. You will not receive your check back from your financial institution.

**Effective date:** Upon signing this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

**Insured patients:** I hereby assign all dental benefits to which I am entitled including private insurance and any other health plans to Premier Dentistry of Eagle.

**Patient name** \_\_\_\_\_

**Responsible party signature** \_\_\_\_\_

**Date** \_\_\_\_\_

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# Premier Dentistry of Eagle

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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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)

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