

• Name of Physician or Clinic: _____ Phone: _____

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

• Do you use controlled substances? Yes No

If yes, please explain: _____

• Do you have a persistent cough lasting longer than 3 weeks? Yes No

If yes, please explain: _____

For Women:

• Are you pregnant or think you might be pregnant? Yes No

• Are you nursing? Yes No

• Are you taking oral contraceptives? Yes No

Missed Appointment Policy: We do our best to arrange customized appointment times to best fit your schedule and your dental needs. Because this time have been reserved especially for you and canceling, rescheduling or missing your appointment will affect many people, it is required that 24 hours notice be given to avoid a fee of \$30. We realize that our schedules are ever changing and are happy to accommodate prior to the 24 hours. In this way it is our desire that you will receive prompt and timely dental care.

_____ initial here

_____ initial here

_____ initial here

_____ initial here

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature (Parent or Guardian If under 18)

Date: _____

I have reviewed my health history information and notified the dental staff of any changes.

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

To be completed by office staff:

Date Initial Blood Pressure Taken By

Date Initial Blood Pressure Taken By

Date Initial Blood Pressure Taken By

Date Initial Blood Pressure Taken By



ASPEN DENTAL

1105 3rd Avenue North
Payette, Idaho 83661
(208) 642-9763

Referral Information:

Whom may we thank for referring you to our practice? Another patient Online Dental Office
 Yellow Pages Sign I'm a Current Patient Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

(if other than patient - must be 18 years or older)

Name: _____

Male Female Married Single

Social Security #: _____ Birth Date _____

Relationship to Patient: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____ (Cell): _____

Street Apartment

City State Zip Code

Email: _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation _____

Address: _____

Street City State Zip Code Phone

Insurance Information

Primary

Name of Subscriber: _____ Is subscriber a patient? Yes No

Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____

Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to subscriber: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Subscriber: _____ Is subscriber a patient? Yes No

Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____

Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to subscriber: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, payment must be received at the time services are rendered. The practice depends upon reimbursement from the patients for the costs incurred in their care. You may pay with cash, check, visa, master card, or you may apply for financing through Care Credit (OAC). Please ask the receptionist for an application. It only takes a few moments to telephone in the application for approval.

Patients who carry dental insurance: Please understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services rendered. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Your co-pay or patient portion is due at each visit. This is only an estimate based on information relating to your benefits. We cannot guarantee the exact amount your insurance will pay.

A service charge of 1 1/2 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of twelve months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

***I also realize that this dental office is in compliance with the HIPAA regulations that were implemented on April 14, 2003 and I understand that a copy of the law is available to me at any time upon my request. Please ask if you have any further questions regarding the HIPAA Law or the privacy of your account with us.

 Date:  Relationship to Patient: 
Signature of Patient or Guardian (If under 18)