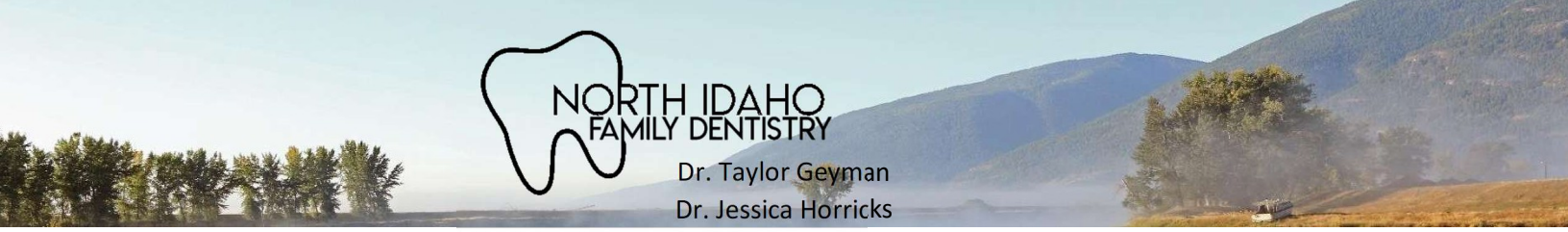

Patient Information and Health History

Name: _____ Preferred Name: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed Gender: □ Male □ Female

Date of Birth: _____ Home Phone: _____

Mailing Address: _____ City: _____State: ____ Zip Code: _____

Physical Address: _____ City: _____State: ____ Zip Code: _____

Email: _____ Cell Phone: _____

How would you prefer to be reminded of appointments? □ Call □ Text □ Email SSN: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about our office? □ Patient Referral (Patient's Name) _____

□ Advertisement □ Internet/Website/Social Media □ Signage □ Other: _____

Are you a Veteran or First Responder? □ Yes □ No If yes, please indicate which one: _____

If patient is a minor or you are not the insurance subscriber, please complete the following section:

Responsible Person/Subscriber: _____ Relationship: _____

Phone: _____

Mailing Address: _____ City: _____State: ___ Zip Code: _____

SSN: _____ Date of Birth: _____

INSURANCE INFORMATION

Do you have Dental Insurance? □ Yes □ Self Pay Insurance Provider: _____
If yes, please give your insurance card to the front desk.

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Responsible Party Signature: _____ **Date:**_____

Dental History

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?	Yes / No	Do you ever experience tooth sensitivity?	Yes / No
Do you experience dry mouth?	Yes / No	Are you currently in pain?	Yes / No
Do you like your smile?	Yes / No		
How many times a day do you brush? _____		How many times a week do you floss? _____	

Have you ever had any of the following diseases or medical problems? Please indicate yes or no.

Anemia	Yes / No	Frequent Nose Bleeds	Yes / No	Kidney Problems	Yes / No
Arthritis	Yes / No	Heart Problems, Specify: _____	Yes / No	Low Blood Pressure	Yes / No
Asthma	Yes / No	Heart Valve Replacement	Yes / No	Pacemaker	Yes / No
Back/Neck Pain	Yes / No	Hemophelia	Yes / No	Prosthetic Cardiac Valve	Yes / No
Bleeding Disorders	Yes / No	Hepatitis A	Yes / No	Radiation	Yes / No
Blood Transfusion	Yes / No	Hepatitis B	Yes / No	Seizures	Yes / No
Cancer	Yes / No	Hepatitis C	Yes / No	Shortness of Breath	Yes / No
Chemotherapy	Yes / No	High Blood Pressure	Yes / No	Sleep Apnea	Yes / No
Chest Pain	Yes / No	History of Head Injury	Yes / No	Stroke	Yes / No
Congenital Heart Disease	Yes / No	HIV+/AIDS	Yes / No	Thyroid Problems	Yes / No
Diabetes	Yes / No	Infective Endocarditis	Yes / No	Tobacco Use	Yes / No
Easy Bruising	Yes / No	Intestinal Problems	Yes / No	Transplantations	Yes / No
Epilepsy	Yes / No	Jaundice/Liver Disease	Yes / No	Tuberculosis (TB)	Yes / No
Frequent Headaches	Yes / No	Joint Replacement	Yes / No	Other: _____	

Medical History (continued)

Pharmacy: _____

Your current physical health is (circle one): Good / Fair / Poor

Are you currently under the care of a physician? Yes / No Please Explain: _____

_____

Are you taking any prescription/over-the-counter drugs? Yes / No *Please list each one or include a list*

Med/Supplement:	Med/Supplement:
Med/Supplement:	Med/Supplement:
Med/Supplement:	Med/Supplement:

Have you taken any Bisphosphonates (such as Fosamax, Reclast, Aredia, or Zometa)? Yes / No

Have you taken any Chemotherapeutic medications? Yes / No

Do you have any allergies? Yes / No If yes, please indicate: _____

Surgical History: _____

For Women: Are you taking Birth Control Pills? Yes / No

Are you pregnant? Yes / No If yes, when is your due date? _____ Are you nursing? Yes / No

How would you rate your dental anxiety? 1 (No anxiety) - 10 (extreme anxiety) _____

Are you interested in Sedation Dentistry? Yes / No

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. I will not hold my dentist or any member of his dental team responsible for errors or ommissions that I have made in completion of this form. It is my responsibility to notify my dentist of any changes in the above medical status.

Patient/Responsible Party Signature: _____ Date:_____

NORTH IDAHO FAMILY DENTISTRY
Dr. Taylor Geyman
Dr. Jessica Horricks
6503 Harrison St, Bonners Ferry, ID 83805
P: (208) 267-0203 F: (208) 943-3161

Notice of Privacy Practices (HIPAA)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I authorize North Idaho Family Dentistry to discuss my dental care (scheduled appointments, treatment plan, etc.) with the following people:_____

_____

_____ _____

Patient/Guardian Signature Date

Patient Name (Print): _____

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy: Cancellation or rescheduling of an appointment with 48 hours or more notification is not considered a broken appointment. Cancellation or rescheduling of an appointment less than 48 hours and up to 24 hours may or may not be considered a broken appointment; it will be at our discretion.

Failure to give 24-hour advance notice:

• We will issue a warning after 1 broken appointment per family in a 12-month period.

• After any additional broken appointments, your family will be placed on a “Same Day Basis.” This means that if you would like an appointment, we would be happy to let you know if we have any availability the day you call.

• When we dedicate 2 or more hours to reserve time for you to see our providers, we require a prepayment of 50% of the estimated cost. If you break an appointment that is 2 or more hours, we will retain the prepayment as a broken appointment fee. This fee will be nonrefundable.

Definition of Broken Appointment: A broken appointment is when you cancel or reschedule an appointment with less than 24-hour notice, or do not show up for the scheduled appointment.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. We also wish to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you, when you fail to keep your appointment without adequate notice, this adds to the overall cost of care as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

Thank you for your understanding,
Taylor Geyman, DDS

I have read and understand the above-mentioned policy.

_____

Patient/Guardian Signature Date