Oak Mountain Dental

YOUR INFORMATION

Today's Date ______________________ Email Address ______________________

Name ______________________ Name I prefer to be called ______________________
Last First MI

Birthdate ____________ Age ________ Social Security # ______________________ ☐ Male ☐ Female

Home Address ______________________
Street City State ZIP

Previous Address (if less than 3 years) ______________________
Street City State ZIP

Home Phone # (   ) __________ Cell Phone # (   ) __________ Work Phone # (   ) __________ Driver's License # __________

Employer ______________________ How long employed? ______________________

Employer's Address ______________________
Street City State ZIP

Marital Status (circle one) : Single Married Separated Divorced Widow Whom may we thank for referring you ______________________

Emergency Contact: Neighbor or Relative not living with you

His/Her Name ______________ Relation __________ Work Phone # (   ) __________ Home Phone # (   ) __________

Address ______________________
Street City State ZIP

Person Responsible for Account if other than yourself

Name ______________ Relation __________ Home Phone # (   ) __________ Social Security # __________

Employer ______________________ Work Phone # __________ Driver's License # __________

Billing Address ______________________
Street City State ZIP

If patient is a minor we need the following information: Mother's Birthdate ______________ Father's Birthdate ______________

SPOUSE INFORMATION

His / Her Name ______________________ Birthdate __________ Social Security # __________

Employer ______________________ Work Phone # (   ) __________ Driver's License # __________

INSURANCE INFORMATION

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______________________

Insured's: DOB __________ SS# __________

Insured's Employer ______________________

Insurance Company ______________________

Insurance Company Address ______________________

Phone # ______________________

Group# __________ ID # __________

Orthodontic Coverage? ☐ YES ☐ NO

If you have a double digit insurance coverage, complete this for the second coverange

Insured's Name ______________________

Insured's: DOB __________ SS# __________

Insured's Employer ______________________

Insurance Company ______________________

Insurance Company Address ______________________

Phone # ______________________

Group# __________ Local # __________

Orthodontic Coverage? ☐ YES ☐ NO

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It is important that I know your medical and dental history. These facts have a direct bearing on your dental health. This information is stricly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

Why have you come to the dentist today? ______________________

How LONG SINCE you have seen a dentist? __________

Last FULL MOUTH X-Rays (Date): __________

(Machine that rotates around your head, or 16 small films)

Are you experiencing problems now? Y N

Please Explain: __________

Your current dental health is GOOD FAIR POOR

Do you wear dentures? (Partials or Full) Y N

Are you unhappy with your dentures? Y N

Would you like to know more about permanent replacements? Y N

Have you had bad dental experiences in the past? Y N

Have you had any gum treatments? Y N

Do your gums bleed, or feel tender or irritated? Y N

Are your teeth sensitive to: Y N

HOT, COLD, SWEETS, PRESSURE? (circle)

Are you aware of GRINDING or CLENCHING your teeth? Y N

Do you have any headaches, ear aches, or neck pains? Y N

Do you have loose, tipped, or shifting teeth? Y N

Have you worn braces on your teeth? (Orthodontics) Y N

Would you like your smile to look better or different? Y N

Do you have a problem with bad breath? Y N

Do you have problems with teeth/fillings breaking? Y N

Do you or have you used products containing tobacco? Y N

Do you regularly use dental floss? Y N

Would you like us to help you learn proper methods of home care, so you can stop dental problems in your mouth? Y N

If you could whiten your teeth at a price anyone could afford, would you do it? Y N

Name of Previous Dentist __________

What do you like best about your smile? __________

What would you like to change about your smile? __________

Which are you most interested in? __________

What do we need to be aware of that may stand in your way of receiving treatment? __________

MEDICAL HISTORY

Do you have any current health problems? Y N If yes, explain: __________

Are you under a physician's care now Y N If yes, explain: __________

Are you currently taking any medication Y N If yes, explain: __________

Are you allergic or have you reacted adversely to any of the following medications? Please circle yes or no.

Asprin	Y N	Percodan	Y N	Erythromycin	Y N
Darvon	Y N	Local Anesthetic	Y N	Valium	Y N
Nitrous Oxide	Y N	Codeine	Y N	Penicillin	Y N
				Other	__________

Do you or have you experienced the following? Please circle yes or no.

Y N AIDS	Y N Chemotherapy	Y N Hay Fever	Y N Kidney Disease	Y N Rheumatic Fever
Y N Allergies	Y N Chicken Pox	Y N Heart Disease/Attack	Y N Liver Diease	Y N Rheumatism
Y N Anemia	Y N Congenital Heart Lesions	Y N Heart Murmur	Y N Low Blood Pressure	Y N Scarlet Fever
Y N Angina Pectoris	Y N Diabetes	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Arthritis	Y N Dizziness	Y N Hepatitus A	Y N Nervous Disorders	Y N Stomach Problems
Y N Artificial Heart Valve	Y N Drug Addiction	Y N Hepatitus B	Y N Pacemaker	Y N Stroke
Y N Artificial Joints	Y N Emphysema	Y N Hepatitus C	Y N Phen Fen	Y N Thyroid Disease
Y N Asthma	Y N Epilepsy	Y N High Blood Pressure	Y N Pregnant - currently	Y N Tuberculosis
Y N Blood Disease	Y N Excessive Bleeding	Y N HIV Positive	Y N Psychiatric Treatment	Y N Ulcers
Y N Bruise Easily	Y N Fainting	Y N Jaundice	Y N Radiation Treatment	Y N Venereal Disease
Y N Cancer	Y N Glaucoma	Y N Jaw Joint Pain	Y N Respiratory Problems	Y N Other

Family Physician __________ Phone # __________

Is there any other Medical or Dental information that you feel I should know about? __________

Blood Pressure __________ Heart Rate / Pulse __________

AUTHORIZATIONS

The undersigned hereby authorized Doctor to take X-rays, study models, photographs or any other diagnotic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all forms of reatment, medication and therapy that my be indicated. I also understand the use of anestheic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself of my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent of Child) __________ Date: __________ DENTIST __________

Jake R. Richards DDS

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payment for dental services is due the day that dental care is rendered. We accept cash, checks, debit cards, and all major credit cards.

Optional Payment Terms:

1. Full Pay Cash Discount: We offer a 5% accounting courtesy discount for all treatment that is paid in full (cash or check) at the time of service.

2. Major Service 2 Payment Option: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the seat date appointment.

3. Credit/Debit Card Payment Option: We allow (with a signed agreement form), a Credit Card Payment option, this allows you to make equal monthly installments by credit card. One-third payment is due at the first appointment; the other two payments are due upon arrangements. Our office personnel will charge these payments to your credit card on the prearranged due dates.

4. Term Loan: By arrangement with Care Credit we offer our patients, upon approval; an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. More flexible payment plans are available upon approval. Please ask for an application.

*****After 90 days all accounts will be forwarded to Outsource Collections. *****

Appointment Policy

Broken appointments:

Your appointment is time that has been reserved especially for you, by you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a possible **$75.00** cancellation fee.

I have read, understand, and accept the above financial policies and commitments. I also understand that if I fail to notify Dr Richards 24 hours in advance of a need to change a scheduled appointment, I will be responsible to pay a charge of $75.00 as a cancellation fee.

Signature of Guarantor ______________________ *Date:* __________

Signature of Patient (if other than guarantor) ______________________

135 Warren Ave
Pocatello, ID 83201

HIPAA

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may compromise the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you do change your mind.
- For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the terms of this notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.
Effective: 07/01/2017

This Notice of Privacy Practices applies to the following organization.
Oak Mountain Dental
Dr. Jake R. Richards DDS, PLLC

I,_______________________________________, acknowledge that I have had the opportunity to read, and request a copy of, the current Oak Mountain Dental, Notice of Privacy Practices.
Signed_______________________________________ Date________________

Patient Name (please print)_____________________________

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***Please print – all persons who can receive private information on this patient's behalf.**

This document is maintained by the Privacy Officer of Oak Mountain Dental: Carol Ward. Phone (208) 237-6453. She can also be reached at: carol@23-smile.us