PATIENT INFORMATION

Whom may we thank for referring you to our office? _____

Last Name _____ First Name _____ MI_____

Soc. Sec. # _____ Date of Birth ____/____/_____ Marital Status___ Sex _____

Mailing Address_____ City _____ State _____

Zip_____ Home Phone _____ Cell Phone_____

Physical Address _____

Employer Name_____ Spouse _____ Date of Birth____/____/_____

Spouse Employer _____ Emergency Contact/Phone #_____

PARENT or GUARDIAN INFORMATION

Fathers Last Name_____ First Name _____ MI_____

Fathers Date of Birth ____/____/_____ Fathers Phone #_____

Fathers Employer Name _____

Mothers Last Name_____ First Name _____

Mothers Date of Birth ____/____/_____ Mothers Phone # _____

Mothers Employer Name _____

Mailing Address _____ City_____ State _____ Zip_____

Primary Insurance	**Secondary Insurance**
Insured Name _____	Insured Name _____
Insurance Company_____	Insurance Company_____
Insurance Company Address_____	Insurance Company Address_____
_____	_____
Insured Employer _____	Insured Employer _____
ID Number _____	ID Number _____
Group Number _____	Group Number _____

PAYMENT AGREEMENT

I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due after 30 days; under this agreement. I will pay interest thereon at the rate of 12% per month (unless otherwise agreed to by the dentist) and pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Signature of Patient/Guardian: _____ Date: _____

Time 8:49 AM

Dr Steven Boyle

Date 7/9/2019

Health and Dental History Form(Copy)

Patient Name:

Birth Date:

Date Created:

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Mental health disorders? Specify:	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes
Do you use tobacco (smoke, snuff, chew, bibis)? If so, how interested are you in stopping?	○ Yes ○ No	If yes
Do you drink alcoholic beverages?	○ Yes ○ No	
If yes, how much alcohol did you drink in the last 24 hours, how much do you typically drink in a week?	○ Yes ○ No	If yes

Dental Information

Do your gums bleed when you brush or floss?	○ Yes ○ No	Does food or floss catch between your teeth?	○ Yes ○ No	Is your mouth dry?	○ Yes ○ N
Have you ever had any problems associated with previous dental treatment?	○ Yes ○ No	Are you currently experiencing dental pain or discomfort?	○ Yes ○ No	Do you have clicking, popping or discomfort in your jaw?	○ Yes ○ N
Are you on a special diet?	○ Yes ○ No	Do you use tobacco?	○ Yes ○ No	Do you brux or grind your teeth?	○ Yes ○ N
Are your teeth sensitive to cold, hot, sweet or pressure?	○ Yes ○ No	Do you have sores or ulcers in your mouth?	○ Yes ○ No	Have you ever had a serious injury to your head or mouth?	○ Yes ○ N

Date of last dental exam:

Date of last dental x-ray:

Women: Are you...

☐ Taking oral contraceptives? ☐ Pregnant/Trying to get pregnant? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Other			

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Blood Transfusion	○ Yes ○ No
Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No	Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No	Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No
Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Parathyroid Disease	○ Yes ○ No	Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No	G.E Reflux/persistent heartburn	○ Yes ○ No				

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Boyle
FAMILY DENTISTRY
1370 East 17th Street
Idaho Falls, ID 83404
(208) 523-3388

HIPAA: NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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 acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____
_____
_____