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DENTAL

PATIENT INFORMATION

Patient Name: _____ **Today's Date:**_____

SS#: _____ **Date of Birth:** _____ **Male**_____ **Female** _____

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed

Mailing Address: _____**Apt#** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Email: _____ **The best way to contact you is:** ___Call ___Email ___Text

In case of Emergency, who should be notified? _____

Phone #: _____ **Relationship:** _____

If the patient is a minor, who is legally responsible? _____

Relationship: _____ **Phone #:** _____

How did you hear about us? ____Insurance ____Google ____Office Sign ____Referral ____Mail ____Other

Who may we thank for your referral: _____

Do you have Insurance for us to bill today? Yes_____ **No**_____

Name of Insurance Co: _____ Phone #:_____
Subscribers Name: _____ Date of Birth: _____ SS#:_____
Group # _____Subscribers ID #_____ Relationship to Subscriber:_____

Does the patient have additional insurance? Yes_____ **No**_____

Name of Insurance Co: _____ Phone #:_____
Subscribers Name: _____ Date of Birth: _____ SS#:_____
Group # _____Subscribers ID #_____ Relationship to Subscriber:_____

****** By signing below I am agreeing that to the best of my knowledge, the above information is correct and up to date. I authorize use of this information when accessing and billing my dental insurance benefits and I hereby consent to treatment performed by the Doctor and staff of Mint Dental.

_____ _____

Patient and/or Parent/Guardian Signature **Date**

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PATIENT MEDICAL HISTORY

Patient Name: _____

Have you ever been hospitalized for a life threatening surgery/illness? ___ Yes ___ No

If yes, please explain:_____

Are you under any medical treatment now? ___ Yes ___ No If yes, please explain:_____

Have you ever taken Bisphosphonate drugs such as Fosamax, Actonel, Boniva, or Reclast? ___Yes ___ No

Do you need to Premed?(premed is usually recommended by your doctor, it means you need an antibiotic before any dental treatment) ___Yes ___No

Are you Pregnant? ___ Yes ___ No **Are you taking birth control?** ___ Yes ___ No

MEDICAL CONDITIONS (Check all that apply):

☐ **High Cholesterol**	☐ **High/Low Blood Pressure**	☐ **Blood Thinners**	☐ **Stroke**	☐ **Heart Attack**	☐ **Artificial Valve**
☐ **Heart Disease/ Pacemaker**	☐ **Heart Surgery**	☐ **Diabetes**	☐ **Glaucoma**	☐ **Arthritis**	☐ **Thyroid Problems**
☐ **Cancer**	☐ **Radiation/ Chemo**	☐ **Kidney/Liver Disease**	☐ **Hepatitis**	☐ **Fainting**	☐ **Stomach Problems**
☐ **Rheumatic Fever**	☐ **Hay Fever/Allergies**	☐ **Organ Transplant**	☐ **Epilepsy/ Convulsions**	☐ **HIV/AIDS**	☐ **Full/Partial Joint Replacement**
☐ **COPD**	☐ **Tuberculosis**	☐ **Asthma/ Respiratory**	☐ **Drug/Alcohol Abuse**	☐ **Herpes Simplex I or II**	☐ **Depression/anxiety**

___**Other**, Please Explain:

_____

List history of cancer/radiation/chemo: _____

ALLERGIES:

___Penicillin ___Sulfa ___Codeine

___Sedative ___Iodine ___Latex ___Local Anesthetic

___Aspirin/Ibuprofen Other: _____

LIST MEDICATIONS:

_____

_____

_____

PATIENT DENTAL HISTORY:

Have you ever had a bad experience in a dental office? ___Yes ___No

When was your last dental visit? _____ What were you seen for?_____

Do you have a history of gum disease? ___Yes ___No Do your gums bleed when you brush? ___Yes ___No

Do you wear a denture, partial or retainer? ___Yes ___No Do you use Tobacco products or Vape? ___Yes ___No

Are you interested in any of the following:
___Teeth Whitening ___Straightening teeth ___ Replacing a missing tooth ___ Changing the shape or look of your teeth

**** By signing below, I certify all above information is correct to the best of my knowledge. I understand that providing incorrect information may be detrimental to my health.**

_____ _____

Patient and/or Parent/Guardian Signature **Date**

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Financial Policy

Thank you for choosing **Mint Dental** as your dental care provider. Our professional dental team is committed to providing you excellent dental care in a friendly, comfortable setting. The following is a statement of our financial policy which we request that you read and sign prior to treatment.

If you have dental insurance, as a courtesy, Mint Dental will work with your insurance to provide an estimated cost of your recommended treatment. Treatment plans and estimated costs are created based upon clinical findings during your diagnostic exam and are subject to change based upon clinical need during your scheduled treatment. If a change in treatment happens it could change the cost of treatment.

The cost of treatment is due at the time of service.

While we do accept assignment of insurance benefits and bill your insurance policy the day of your appointment, your portion of each service is due at the time services are rendered. This will be based on an estimate of what insurance will pay. We accept cash, check, debit card, Visa, MasterCard, Discover, American Express and Care Credit. **Interest on unpaid balances beyond 90 days may be applied at the rate of 1.5% monthly (18% annually).**

Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. We do, however, submit dental claims as a courtesy and will do our best to assist you in understanding and applying your dental benefits. All treatment estimates are provided based upon information from your insurance company and are **estimates only. We cannot guarantee insurance payments or payment amounts.**

It is our recommendation that you study and know your insurance policy. If your insurance company has not paid your account in full within 90 days of billing, we require the balance to be paid directly by you via cash, check, debit or credit card. Return checks are subject to an additional fee of $25.00. Unpaid balances are subject to action by a collection agency.

If you have any further questions regarding our financial policy, please ask a member of our dental team.

By signing below, I give permission for **Mint Dental** to release necessary information regarding my treatment to my insurance company(s) and assign dental benefit payments directly to **Mint Dental.**

I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

Patient Name (Please Print) : _____ **Date:** _____

Patient or Parent/Guardian Signature: _____

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24-hour Cancellation & Rescheduling Policy

Your appointments are very important to the Mint Dental team, they are reserved especially for you. We understand that sometimes schedule adjustments are necessary, therefore, we respectfully request at least **24-hour** notice for cancellations or rescheduling of appointments.
The **24-hour** cancellation gives us time to inform our wait list patients of the availability, as well as keep our staff's schedule filled, thus better serving everyone.

Please understand that it is your responsibility to remember your appointment dates and times. Because we know how easy it is to forget an appointment you booked months ago, as a courtesy, you will receive a two week reminder text and/or email, a one week reminder text and/or email, and then a confirmation text and/or email two days before your scheduled appointment.

The day of your appointment, one of our staff will call at **5 minutes past** the hour of the scheduled appointment to verify the appointment status. **Any late arrival could shorten your appointment time and will not be made up by running into the next patient's scheduled appointment.**

If you do not call to cancel or fail to show up for a scheduled appointment without **24-hour** notice, you will be reminded of this policy. **Continual disregard of this policy will result in you losing the privilege to make your appointments in advance and/or you will be required to pay your portion of the scheduled treatment at time of scheduling.**

Thank you for viewing and supporting our **24-hour cancellation and rescheduling policy.** Mint Dental's policies are presented and provided in the best quality and tradition of excellent service for our established and future patients. Please help us serve you better by keeping scheduled appointments.

By signing below, you are agreeing that you have read the **24-hour cancellation policy** in its entirety and agree to the terms and conditions.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed. It also explains how to obtain access to this information. **Please review it carefully.**

The Health Information Portability and Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of the health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care. **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization reviews. For example, we disclosed treatment information when billing insurance for your treatment. **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending postcards and/or leaving messages at home/work. Any other uses are disclosures will be made only with your written authorization. You may revoke such authorization and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Office at the practice address listed below. The right requested restrictions on certain uses and disclosures of protected health information including those related to disclosures to family member, other relative, close personal friends, or any other person identified by you. We are however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to request to received confidential communications of protected health information from us by alternative or at alternative locations. The right to access, inspect, and copy your protected health information. You have the right to request an amendment to your protected health information. The right to receive an accounting disclosures of protected health information outside of treatment, payment and health care operations. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 15, 2003** and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revises Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of health and Human Services Office of Civil Rights, in the event you feel your privacy right have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Kevin Pulsipher, DMD
Bernt White, DMD, Warren Willis, DMD
3877 E Amity Rd Meridian ID 83642
(208)519-7713

For more information about HIPPA or to file a complaint:

US Department of Health & Human Services
Office of Civil rights
200 Independence Ave, SW Washington, DC 20201
(877)696-6775 (toll free)

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

If you are filling out our new patient forms in the office, the **'Notice of Privacy Practice'** form is attached to the clipboard, it is titled **'Notice of Privacy Practice'**. By handing you the clipboard you are receiving the **'Notice of Privacy Practice'** form. At any time if you would like a copy of this form please ask a member of the staff at the front desk. If you are filling out the new patient forms at home, you should have received a printed copy of this form.
This Notice describes in detail how we might use or disclose your protected health information. The Notice also explains your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgment.

By signing this form, you acknowledge that you have received our 'Notice of Privacy Practice' form and understand that you have the option to receive a copy by asking a member of the front office staff.

(Please check one of the following)

****** I have received the **Notice of Privacy Practice** form and asked for a copy _____

****** I have received the **Notice of Privacy Practice** form but declined a copy _____

_____
Patient Name (Please Print)

_____ _____
Patient or Parent/Guardian Signature **Date**