



BLAISDELL DENTAL CENTER

• Caldwell, Idaho 83605 • (208) 459-2376 •

Dr. Tom L. Blaisdell

ABC

The first visit is on a cash basis. We accept personal checks or major credit cards. As a courtesy, we file claims for most insurance companies. Co-payments and deductibles are due at each visit.

Patient Name _____
Last First Middle

Full Address _____

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent or guardians' name _____

Are you a member of the Armed Forces? _____

Person responsible for payment of account _____
Last First Middle

Full Address _____

How long at this address _____ Home phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Cell Phone _____

Employer _____ Occupation _____ No. years employed _____

Spouse _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ No. years employed _____

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

Insurance Information

Insured Name _____ Social Security # _____
Last First Middle

Insurance Co. _____ Group # _____ Local # _____

Full Address _____

Do you have dual coverage? Yes No If Yes, Second Insured's Social Security # _____
Second Insured's Name _____

Insurance Co. _____ Group # _____ Local # _____

Insurance Co. Address _____

Insured's Employer _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Patient or parent of minor) _____

Signed (Patient, or parent if minor) _____ Date _____

Emergency Information

Name of someone who will always know your address _____

Full Address _____ Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Patient's or parent's signature (if minor) _____

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

- 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
- Have you ever had a serious head or neck injury? Yes No If yes
- Are you taking any medications, pills, or drugs? Yes No If yes
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No

Women: Are you...

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

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

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

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

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

Comments:

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: _____

Blaisdell Dental Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance, we are always available to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance. Minors MUST be accompanied by an adult for all treatment.

We accept CASH, CHECKS, DEBIT/CREDIT CARDS, CARE CREDIT. Financial arrangements are available upon request, prior to treatment.

In most instances we accept assignment of insurance benefits, in which case, **your estimated portion of each service is due at the time services are rendered.** Those who have dual coverage should discuss their payment plans with the receptionist.

We will gladly discuss your proposed treatment and answer any questions regarding your insurance.

HOWEVER:

1. YOUR insurance is a contract between you, your employer and the insurance company.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Should your insurance take longer than 60 days to pay, we would ask that you take care of the balance due and then be reimbursed if and when we receive the insurance payment.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are Your Responsibility from the day the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. **WE ARE HERE TO HELP YOU!**

Returned Checks are subject to an additional \$25 fee.

Cancellation Policy

Our time is as important as yours. We attempt to schedule as efficiently as possible to reduce waiting time. **We require patients to give 24 hours notice to cancel or reschedule appointments. A Broken Appointment Fee of \$55 is charged when the patient does not show up for an appointment or give 24 hours notice.**

Finance Charge

Any outstanding balance which is overdue by more than 30 days will have a 1.75% APR finance charge.

PRINT NAME _____

Date _____

RESPONSIBLE PARTY SIGNATURE _____



Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to this date I revoke this consent is not in effect.

Signed this date: _____

Print Patient Name: _____

Relationship to Patient _____

Signature: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (please specify)
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