



ADVANCED
DENTAL CARE
of Twin Falls

247 River Vista Place Suite 200
Twin Falls, Idaho 83301
www.twinfallssmiles.com
(208) 734-8080

PATIENT REGISTRATION

Name: _____ Preferred Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Can we contact you by text/email for appointment reminders? _____

Date of Birth _____ Occupation _____

Employer _____

Marital Status: Single Married Divorced Widowed Gender: Male Female

Spouse's Name _____ Spouse's Employer _____

Emergency Contact Name: _____ Phone: _____

Relationship: _____

If patient is a Minor, please give parent or guardian's name: _____

Who is responsible for this account? _____

How did you hear about our office? _____

INSURANCE INFORMATION

Subscribers Name: _____ Relationship to Patient: _____

Subscriber ID#: _____ Subscriber Birthdate: _____

Insurance Company: _____ Group#: _____

Is the patient covered by additional dental insurance? Yes No If Yes, please fill in information:

Subscribers Name: _____ Relationship to Patient: _____

Subscriber ID#: _____ Subscriber Birthdate: _____

Insurance Company: _____ Group#: _____

I certify that I (or my Dependent) have insurance coverage as indicated and assign directly to Advanced Dental Care of Twin Falls 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.

Responsible Party Signature: _____ Date: _____



Reason for today's visit? _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Previous Dentist: _____

Mark "Yes" or "No" if you presently have or previously had any of the following:

- | | | | |
|-------------------------------|--|-------------------------------------|--|
| Bad Breath | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bite your lips or cheeks regularly? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bleeding Gums | Yes <input type="checkbox"/> No <input type="checkbox"/> | Blisters on lips/mouth | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chew on one side of mouth | Yes <input type="checkbox"/> No <input type="checkbox"/> | Dry Mouth | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Food collection between teeth | Yes <input type="checkbox"/> No <input type="checkbox"/> | Grinding Teeth | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Gums Swollen/ Tender | Yes <input type="checkbox"/> No <input type="checkbox"/> | Jaw Pain/ Tiredness | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Mouth Breathing | Yes <input type="checkbox"/> No <input type="checkbox"/> | Orthodontic Treatment | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Pain around ear | Yes <input type="checkbox"/> No <input type="checkbox"/> | Periodontal (gum) treatment | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Sensitivity to cold | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sensitivity to hot | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Have you experienced:

Clicking or popping of the jaw Yes No

Difficulty in opening or closing mouth Yes No

Do you like your smile? Yes No

How often do you brush? _____

How often do you floss? _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with dental work? Yes No

Do you feel nervous about having dental treatment? Yes No

Have you ever had a bad experience in a dental office? Yes No

If yes, please describe

Is there anything else about having dental treatment you would like us to know?



Your Physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No If yes, please explain:

Are you taking any prescription/ over the counter drugs? Yes No If yes, please list each one:

Do you smoke or use tobacco? Yes No

For Women:

Are you taking birth control pills? Yes No

Are you pregnant or trying to become pregnant? Yes No

Are you nursing? Yes No

Do you have or have you had any of the following diseases or medical problems? No to All

Abnormal Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alcohol/ Drug Abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV+ /AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Bones/Joints/Valves	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bruise Easily	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty Breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic/Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sexually Transmitted Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting Spells	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Frequent Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumors	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hemophilia	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Do you have or have you had any disease, condition, or problem not already listed? Yes No

If yes, please describe: _____

Have you been hospitalized during the past 12 months? Yes No If yes, please explain:

Are you allergic to any of the following: No to All

Amoxicillin Yes No Latex Yes No

Aspirin Yes No Metals Yes No

Clindamycin Yes No Penicillin Yes No

Codeine/Hydrocodone Yes No Sulfa Yes No

Dental Anesthetics Yes No Tetracycline Yes No

Erythromycin Yes No

Other? _____

I certify that the 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 of his team members responsible for errors or omissions that I have made in the completion of this form. It is My Responsibility to notify my Dentist of any changes in my medical status.

Patient or Responsible Party Signature _____ Date _____



ADVANCED
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Cancellation Policy

Our team at Advanced Dental Care is dedicated to quality care and exceptional service. Our doctors and team spend extensive time preparing for each individual reservation. Broken appointments affect three people- you, because your dental needs have not been met, the doctor or hygienist who was prepared for your appointment, and another patient waiting to receive needed dental care.

If you find that you must change your appointment, we require a minimum of 48 hours notice. If proper notice is not received, a fee of \$45 will be charged to your account.

Appointment Reminders In order to do our part to help you remember your appointments, we will provide you with reminders by text, email, or both. The reminders come at the following times:

*Upon scheduling an appointment so you can add it to your calendar

*2 weeks before appointment

*3 days before appointment to allow time to make changes **before** the 48 hour required notice

*2 hours before your appointment

****These frequencies can be customized to fit your needs. Contact our front desk.****

You may easily confirm appointments thru text by replying "YES". Changes to appointments are only accepted by calling our office directly (208)734-8080.

A reminder phone call will be given to any unconfirmed appointments the day before the scheduled appointment. Any changes made at this time will be subject to the cancellation fee.

I Understand the Cancellation Policy of Advanced Dental Care of Twin Falls

Signature _____ Date _____



ADVANCED
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Financial Policy

We, the staff of Advanced Dental Care of Twin Falls, thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest quality care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities; please feel free to contact us at (208)734-8080.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. **We strive to keep our prices low for our area.**

Payment for services is due at the time of service.

We accept the following forms of payment: Cash, Check, and All major credit cards. **We offer a 5% cash discount when paid in full at time of service.** This discount is reserved for patients without insurance benefits and cannot be combined with any other offer.

Other Payment Options We offer **easy-to-budget** monthly payments thru Care Credit (third party financing.) They offer a variety of **INTEREST FREE** options in 6, 12, 18 and 24 month plans.

INSURANCE

Your **estimated** co-payment will be due at the time of service. We are happy to submit the claims necessary to help you receive the full benefits of your coverage; however, **we cannot guarantee any estimated coverage.** Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. We allow insurance 45 days to make payment at which time the balance becomes your responsibility.

Unpaid Accounts

Any account balances left **unpaid past 90 days** of treatment date, **will be sent to a Collections Agency.** The agency will add approximately 50% to the balance. Patient will be responsible for all fees associated with this process.

We also realize that temporary financial situations 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. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff to discuss any concerns you may have. Thank you for understanding our Financial Policy.

I have read and agree to the Financial Policy of Advanced Dental Care of Twin Falls

Signature of Patient or Responsible Party _____ Date _____