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:_____

ADVANCED DENTAL CARE of Twin Falls

Dental History

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 ☐ No☐	Bite your lips or cheeks regularly?	Yes ☐ No☐
Bleeding Gums	Yes ☐ No☐	Blisters on lips/mouth	Yes ☐ No☐
Chew on one side of mouth	Yes ☐ No☐	Dry Mouth	Yes ☐ No☐
Food collection between teeth	Yes ☐ No☐	Grinding Teeth	Yes ☐ No☐
Gums Swollen/ Tender	Yes ☐ No☐	Jaw Pain/ Tiredness	Yes ☐ No☐
Mouth Breathing	Yes ☐ No☐	Orthodontic Treatment	Yes ☐ No☐
Pain around ear	Yes ☐ No☐	Periodontal (gum) treatment	Yes ☐ No☐
Sensitivity to cold	Yes ☐ No☐	Sensitivity to hot	Yes ☐ No☐

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?

_____

_____

_____

ADVANCED DENTAL CARE of Twin Falls

Medical History

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

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 DENTAL CARE of Twin Falls

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 DENTAL CARE of Twin Falls

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_____

ADVANCED DENTAL CARE of Twin Falls

Receipt of HIPAA Policies and Procedures

I have received and reviewed a copy of this office's Authorization for Release, HIPAA Consent, and Notice of Privacy Practices.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

In addition to other Dental Offices, Persons with whom this office may share my personal information with:

_____

_____

Signature of Patient or Responsible Party_____Date_____