

# Kootenai Dental Group

Dr. Delwyn Dick and Dr. Lamont Murdoch

## Patient Registration Form

### **Patient Information:**

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_\_\_ Male  Female  Married  Single  Minor

SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_@\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_ Best Way to Reach me: Text  Call

How did you hear of us? \_\_\_\_\_

If referred by someone, whom may we thank for the referral? \_\_\_\_\_

### **Emergency Contact: (Guardian Information if Minor)**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_ Best Way to Reach me: Text  Call

### **Financial / Insurance**

No Insurance / Self pay

#### **Primary Dental Insurance Information:**

Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_\_\_ SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: Self  Spouse  Child  Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

#### **Secondary Dental Insurance Information:**

Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_\_\_ SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: Self  Spouse  Child  Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

### **Medical and Dental History:**

- |  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Artificial Valve/Joint | <input type="checkbox"/> Autism             | <input type="checkbox"/> Bleed/Bruise Easily |
| <input type="checkbox"/> Blood Transfusion     | <input type="checkbox"/> Cancer / Chemo | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Epilepsy/ Seizure   |
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Heart Attack   | <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Heart Surgery      | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> HIV/AIDS       | <input type="checkbox"/> Implant / Transplant   | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> Low Blood Pressure  |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pacemaker      | <input type="checkbox"/> Psychiatric care       | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Severe Headaches    |
| <input type="checkbox"/> Sinus Problems        | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Thyroid Problems       | <input type="checkbox"/> Tuberculosis       |  |

Please list any medical condition not listed here: \_\_\_\_\_

Please list all medications you are currently taking here: \_\_\_\_\_

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**If you have a list, please bring to the front desk and we will scan into your chart.**

**Are you allergic to any of the following?**

Aspirin     Codeine     Dental Anesthetics     Erythromycin     Ibuprofen     Latex  
 Penicillin     Sulfa     Tetracycline     Tylenol     Other \_\_\_\_\_

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain?  YES     NO    Do your Gums Bleed?  YES     NO

Do you brush your teeth twice a day  YES     NO    Do you floss regularly  YES     NO

Do you now have or have you ever experienced pain/ discomfort in your jaw (TMJ)?  YES     NO

Have you ever had problems with previous dental treatment?  YES     NO

If yes, please explain: \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Have you ever had a serious head, neck, or back injury?  YES     NO

Medical Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

**WOMEN** Are you or could you be pregnant?  YES     NO *If yes, how many weeks?* \_\_\_\_\_ Nursing?  YES     NO

**General Consent**

1. During the course of treatment, I may undergo procedures in all phases of dentistry. Some of the procedures may be performed by a dental profession other than the dentist including a dental assistant or dental hygienist that have been trained and certified by the State of Idaho.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. Payment is due the day of service and I am responsible for the full amount owed regardless of any insurance policy I may or may not have. The practice will help in filling any forms needed for insurance reimbursement and those payments will be given to the patient. There is no guarantee that an insurance company will cover work that may be performed.

5. PHOTO CONSENT: I grant permission for Dr. Delwyn Dick and Dr. Lamont Murdoch for the use of the photograph(s) or electronic media images for educational purposes and in any presentation of any and all kinds including marketing. (This will be of your smile only and not full-face photos.)

6. Missed appointments/Short notice cancellations: Without 48 hours advance notice, there will be a fee of \$50 for any missed appointments. The missed appointment fee must be paid prior to future office visits.

7. HIPAA Compliance: I grant Delwyn Dick DDS permission to send out all reminders via all forms of communication by the information I have provided whether phone, email or mailing.

8. Notice of Privacy Practices:

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice took effect April 14, 2012, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time.

We use and disclose health information about you for treatment, payment and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use or disclose your health information to obtain payment for services we provide you. We may use and disclose your health information with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications certification, licensing or credentialing activities.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**To help us serve your dental needs best, we would like to know more about you.**

**Please take a moment to complete the following questions:**

- Do you experience any apprehension before or during dental visits? If so, please explain.

\_\_\_\_\_

- On a scale of 1-10 (10=highest), how would you rate your dental health?

\_\_\_\_\_

- Have you ever had gum disease? Has anyone in your family suffered from gum disease?

\_\_\_\_\_

- What is your biggest dental health concern?

\_\_\_\_\_

- Have you or anyone in your family been diagnosed or treated for oral cancer?

\_\_\_\_\_

- Are there foods you enjoy but cannot eat due to discomfort with your teeth?

\_\_\_\_\_

- If you could improve anything about your smile what would that be?

\_\_\_\_\_