



Patient Information

Legal Name _____

I prefer to be called: _____

Birthdate: _____ Male Female

Home Address: _____

Hm # _____ Cell# _____

Wk# _____ Preferred number: Cell Hm Wk

E-mail _____

Employer: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Previous/Present Dentist _____

Last Visit Date: _____

In the event of an emergency, whom should we contact?

Best # to reach your contact _____

Dental Insurance

Do you have dental insurance that we'll be billing for you?

Yes _____ No _____

If so, please present your insurance card to the financial coordinator

Dental History

How would you describe the condition or your teeth or gums? _____

Are you currently in any pain or discomfort? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Do your gums bleed when you brush or floss? _____

Are you happy with your smile? _____

Have you experienced pain in your jaw joint? _____

Do you clench or grind your teeth? _____

Do you have sleep apnea? _____ Do you use a CPAP? _____

I understand that the information is correct to the best of my knowledge and it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the release of information for insurance purposes and give consent for Dr. Fehling and her staff to treat me.

Signature of Patient or Responsible Party: _____ Date: _____

Medical History

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

- Angina / Taking heart meds
Heart Murmur / Heart valve problem
Pacemaker
Taking Coumadin or Anticoagulants
Blood Pressure problems
Abnormal bleeding
Botox or Dermal Fillers
Asthma
Joint replacements (total hip, pins, or implants)
Are you required to take antibiotics before dental treatment?

Women:

- Taking Birth Control Pills
Are you pregnant?
How many weeks: _____

Are you allergic to or have you reacted adversely to any of the following:

- Local anesthetics
Sulfa drugs
Codeine or other narcotics
Reaction to metals
Penicillin or other antibiotics
Aspirin, acetaminophen, or ibuprofen
Latex or Rubber Dam
Other: _____

Misc. Concerns:

- Diabetes
Fainting spells
Do you smoke or chew tobacco
HIV / AIDS
Cancer / Tumor
Seizures or Epilepsy
Hepatitis

Current List of Medications



Welcome

Thank you for choosing Element Dental for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

Payment

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

- Cash, Checks, Visa, MasterCard, Discover and American Express
- Monthly payment plans through Care Credit.

Insurance

If you belong to a traditional insurance plan, our team can assist you by filing your insurance claim as a benefit to you. However, please be prepared to pay any patient portions and/or deductibles in full at the time of service. Your portion is estimated ahead of time for you, so you will have no question how much will be due that day. Be aware that the balance incurred at our office is your personal responsibility regardless of your insurance company's payment and coverage. Coverage amounts vary from policy to policy, and it is your responsibility to seek coverage amounts and limits of liability on your insurance policy. Please understand that your insurance policy is a contract between you and your insurance company. Element Dental holds no party to that contract and will not be responsible in the event your insurance company denies any claim.

Minors

Payment for services for the treatment of minors can be made by check, cash, Care Credit, credit card and is the responsibility of the adult accompanying that minor.

Missed Appointments

Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a fee for all canceled or missed appointments without 48-hours notice.

Service Charges

The policy of this office is to apply an 18% annual percentage rate or a billing charge to all accounts over 60 days past due. There will also be a \$40.00 fee for returned checks.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

Signature of patient/responsible party

Date



PATIENT PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Element Dental is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation We may disclose your health information as necessary to comply with Compensation Laws.

Emergencies We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons. We may disclose your health information to coroners or medical examiners.

Organ Donation. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies. We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership. In the event that Element Dental is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Element Dental is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Element Dental amend your protected health information. Please be advised, however, that Element Dental is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Element Dental.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices Element Dental reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Element Dental is required by law to comply with this Notice.

Element Dental is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us.

Complaints Complaints about your Privacy rights, or how Element Dental has handled your health information should be directed to Dr. Rachel Fehling, by calling this office at (208) 664-2160. If Dr. Rachel Fehling is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Signature of Responsible Party

Date