IDAHO PERIO
Center for Dental Implants & Laser Periodontal Therapy

PATIENT REGISTRATION

Full Name: _____ Date of Birth: _____

Address: _____ Soc Sec #: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Email Address: _____ Cell phone: _____

Employed By: _____ Occupation:_____

Parent/Spouse Name: _____ Soc. Sec. # _____

Employed By: _____ Occupation: _____

INSURANCE INFORMATION

Primary Dental Insurance Co: _____ Subscriber #: _____

Primary Insured's name: _____ DOB: _____ Group #: _____

Second Dental Insurance Co: _____ Subscriber #: _____

Second Insured's name: _____ Group #: _____

CONTACT /REFERRAL INFORMATION

Your Dentist: _____ How Long? _____

Physician: _____ City: _____ How Long? _____

Emergency Contact: _____ Telephone: _____

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

We will be happy to assist you with filing claims for pre-determinations and for insurance benefits. However, you must realize that we render services to the individual, not the insurance companies. You are responsible for the payment of your account. We cannot accept responsibility for collecting insurance claims or for negotiating a disputed claim, but we will provide what assistance we can.

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HEALTH HISTORY FORM

Name: _____ Date: _____

PLEASE DESCRIBE FULLY ANY YES ANSWERS:

Date of last physical examination: _____ Purpose of exam: _____
Findings: _____

Are you currently being treated for any medical conditions: Yes No
If yes, for what? _____

ARE YOU REGULARLY TAKING ANY OF THE FOLLOWING MEDICATIONS? (If yes, please circle)

Chemotherapy for Cancer
Prescribed pain medications
Anti- anxiety medications
Insulin, Orinase or similar drug
Antibiotics
Steroids such as Prednisone
Fosamax or similar drug for Osteoporosis
Other: _____

Anticoagulants/Blood thinners
Medications for High Blood Pressure
Prescribed Aspirin Regimen
Nitroglycerin
Digitalis or drugs for heart trouble
NSAIDS or Arthritis medications **Herbal remedies/supplements**

WHAT MEDICATIONS AND DOSAGES ARE YOU CURRENTLY TAKING?

_____ _____
_____ _____
_____ _____

ARE YOU ALLERGIC TO OR HAD ANY UNUSUAL REACTIONS TO ANY OF THE FOLLOWING MEDICATIONS? (If yes, please circle)

Local Anesthetics ("Novocaine")
Penicillin
Sulfa
Tetracycline
Aspirin
Anti-inflammatory meds
Morphine
Codeine
Sedatives
Adhesives
Latex or rubber products

Other Antibiotics: _____
Other Pain Medications: _____
Other over the counter Medications: _____
Other Medications: _____

Anaphylaxis Reaction to: _____

No known drug allergies: _____ **(initial)**

Woman Only

Are you taking contraceptives or hormones: Yes No
Are you pregnant or breast feeding: Yes No
expected delivery date: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Pain in your chest upon exertion: Yes No
Abnormal bleeding after surgery or trauma: Yes No
Been diagnosed with diabetes: **Type I** **Type II** Yes No
If so, when and what was your most recent A1C? **Date:** _____ **Results:** _____
Any of your family members been diagnosed with diabetes: Yes No
If so, who: _____
Used combination Phen-fen: Yes No
Pain in your teeth or jaw joints: Yes No
Clinching or grinding your teeth: Yes No
Previous periodontal treatment or diagnosis: Yes No
If so, what: _____
Use tobacco in any form: Yes No
If so, what form: _____
Are you interested in quitting? Yes No

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE:

Chest pain
Artificial Heart Valve
High Blood Pressure
Congenital Heart Disease
Heart Failure
Heart Murmur
Heart Attack
Pacemaker/Defibrillator
Rheumatic Fever
Blood Clots
Stroke
High Cholesterol
Asthma
Emphysema
Tuberculosis
Osteoporosis
Artificial Joint
Arthritis
Thyroid Disease
Blood Disorder
Hepatitis
Liver Disease
HIV Positive/Aids
Radiation Treatment for Cancer
Glaucoma Narrow or Wide Angle
Vertigo
Fainting/Dizzy Spells
Epilepsy/Seizures
Nervousness
Ulcers
Canker Sores
Anaphylaxis Reaction
Psychiatric Treatment
Alcohol/Drug Addiction

Other medical conditions: _____

Anything you would like to discuss with our doctor today?

_____

Signature: _____ Date: _____

Periodontal disease is caused by a combination of complex factors and the above asked questions are designed to help us identify them. The success of therapy is dependent upon this. Therefore, although some of the questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral health, and all answers are kept confidential.

A MESSAGE ABOUT YOUR INSURANCE

It is very important to us that you understand our office policy regarding insurance.

Although we are happy to file your insurance claim for you, please understand that we are **NOT** affiliated with your insurance company in any way. We are **OUT OF NETWORK** with all insurance plans and companies. Your plan and associated coverage is between you and your insurance company. Many plans have out-of-network benefits, and we will do our best to inform you if your particular insurance does not.

We will do our best to file your insurance claim and provide the necessary information requested by your insurance company. We cannot be held responsible for claims not paid by your insurance. **Any claim not satisfied by your insurance company becomes your sole responsibility**.

If you have any concerns or questions regarding how much of your procedure will be covered by your insurance plan, please contact your insurance provider. We provide every patient with a treatment plan that has the exact dental codes for the procedures we have recommended. We encourage you to call your insurance with those codes to find out what, if anything, they will cover.

When talking to your insurance company there are a few key pieces of information you will want to find out:

- Are the codes we recommended listed as covered benefits by your insurance company?
- What is the allowable for each code? (This is the fee your insurance has "allowed" for each procedure. This may differ from our fees.)
- What percentage of the allowable does your insurance cover?
- What is remaining on your annual maximum? (The maximum amount your insurance will pay in a year.)

Example: Our fee for a surgical extraction is $319. If the insurance allowable is $200 and they cover 50% of the allowable, the insurance company will ***estimate*** *$100 in coverage and $219 as the patient responsibility.*

We can submit a pre-authorization to your insurance company, however **we do not follow up on pre-authorizations**. Your insurance company is not required to send pre-authorizations to our office, and they may choose to disregard the request. However, they are required to provide you with a verbal pre-authorization. **The fastest way to get answers as to what they will cover is to call your insurance company with the dental codes we provide you.**

Again, we are happy to file your claim for you as a courtesy to you, our valued patient.

We cannot be held responsible for the coverage of your insurance plan, but we will do our best to maximize your benefits.

If you have any questions please feel free to ask our office staff.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 in effect. This Notice takes effect April 14, 2003 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, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make a new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, of for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversights, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization;
- to advert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation law.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of the notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying cost, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost base fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for addition restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health was incorrect, or
- we should communicate with you by alternative means or at alternative location,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jace Hansen
Telephone: (208)377-2777 Fax: (208)377-3075
E-mail: idahoperio@gmail.com
Address: 6019 N Eagle Rd Boise ID 83713

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to the Patient;

We are required by law to provide you with a summary of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

By signing below, I acknowledge that I have received a copy if Idaho Perio's Notice of Privacy Practices.

_____

Name (please print)

_____

Signature Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you would like to authorize our office to discuss your care with. Your PHI maybe disclosed to the individual(s) listed below until you notify us in writing otherwise.

_____ _____

_____ _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices summary, but it could not be obtained because:

☐ The patient refused to sign document.

☐ Due to an emergency situation it was not possible to obtain acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other (please provide specific details)

_____

_____

_____ _____

Employee Signature Date