MAPLEGROVE DENTISTRY

208.853.2221
208.853.2223 fax

3270 N Maple Grove Rd
Boise, ID 83704

MAPLEGROVEDENTISTRY.NET

We would like to get to know you better!

Name_____ ❑ Male ❑ Female ❑ Married ❑ Single

Preferred Name_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Date of Birth _____

Occupation_____ Employer_____

Spouse or Parent's Name_____ Their Phone_____

Whom may we thank for referring you? _____

Person to Contact in case of Emergency_____ Phone_____

Person Responsible for Dental Investment_____

For Insurance Purposes:

Name of Policy Holder_____ DOB_____ Relationship to Patient_____

Insurance Company_____

Insurance Co. Number_____ Group Number_____

HIPPA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist and business office staff. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the email or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients is an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards, and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs in regards to privacy issues, please put them in writing for the office so that we may address your concerns. You acknowledge that you may request and receive a copy of your *Notice of Privacy Practices* that contains a more complete description of the uses and disclosures of your health information. You understand that the *Notice of Privacy Practices* may change but that you may contact us at any time to obtain a current copy.

Financial Information

I have read and answered the above questions to the best of my knowledge. I authorize the doctor and/or his staff to release all information necessary to secure payment of my benefits from my insurance company. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me.

I understand that fees may vary at the time of service due to the extent of treatment. Fees are estimates only and estimates are not a guarantee of payment by my insurance company. I understand that the payment of this account is my responsibility, regardless of the amount my insurance company reimburses before or after payment is made. **I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

Patient Signature_____ Date_____

Dentist/Hygienist Signature_____ Date_____

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PATIENT NAME_____

MEDICAL HISTORY

PLEASE CIRCLE (Y) FOR "YES" OR (N) FOR "NO" FOR ANY OF THE FOLLOWING WHICH MAY APPLY TO YOU NOW OR IN THE PAST. **PLEASE UNDERLINE ANY APPLICABLE CONDITION.**

Y N HEART ISSUES INCLUDING THE FOLLOWING
HEART ATTACK CONGENITAL HEART DISEASE
HEART VALVE DISORDER PACEMAKER
HIGH BLOOD PRESSURE STROKE
HEART MURMUR CHEST PAIN
Y N ARTIFICIAL JOINT OR IMPLANT
WHEN? _____WHICH JOINT: _____
Y N ANEMIA OR BLOOD DISORDER
Y N TAKE ANTIBIOTICS FOR DENTAL APPOINTMENT
Y N BLOOD THINNERS (WARFARIN/COUMADIN)
Y N DIABETES: TYPE I TYPE II
Y N OSTEOPOROSIS/OSTEOPENIA
Y N HISTORY OF BISPHOSPHONATE USE
(FOSAMAX, BONIVA, ACTONEL, RECLAST, ETC)
Y N ORGAN TRANSPLANT
Y N THYROID DISEASE
Y N ASTHMA, EMPHYSEMA, COPD

Y N SINUS PROBLEMS
Y N ULCERS, REFLUX, OR HEARTBURN
Y N DIGESTIVE DISORDERS
Y N KIDNEY PROBLEMS
Y N LIVER DISEASE
Y N AUTOIMMUNE DISORDER
Y N FAINTING OR BLACKOUTS
Y N HEADACHES OR MIGRAINES
Y N EPILEPSY OR SEIZURES
Y N TUMORS, CANCER, RADIATION TREATMENT
CANCER TYPE:_____
Y N TUBERCULOSIS
Y N HEPATITIS A, B, C OR D
Y N AIDS OR HIV INFECTIONS
Y N PSYCHIATRIC DISORDERS
Y N TOBACCO USE?
Y N DRUG/ALCOHOL USE?

IS THERE ANY FAMILY HISTORY OF THE FOLLOWING?

Y N HEART DISEASE Y N STROKE Y N DIABETES
Y N EARLY TERM BIRTH Y N CANCER Y N LUNG PROBLEMS

HAVE YOU SEEN A PHYSICIAN OR BEEN HOSPITALIZED IN THE LAST TWO YEARS (INCLUDING PREGNANCY)? Y N

IF YES, PLEASE EXPLAIN_____

PHYSICIAN'S NAME AND PHONE:_____

HAVE YOU EVER HAD AN ALLERGIC REACTION TO A DENTAL ANESTHETIC OR DRUG SUCH AS **PENICILLIN**, SEDATIVE, **LATEX**, ASPIRIN OR METALS? IF YES PLEASE EXPLAIN_____

IF FEMALE, ARE YOU CURRENTLY PREGNANT OR TRYING TO BECOME PREGNANT? _____

IF YES, WHEN ARE YOU EXPECTING?_____ ARE YOU NURSING? Y N

WHAT PRESCRIPTION OR OTC DRUGS, MEDICATIONS, VITAMINS, OR HERBS ARE YOU TAKING AND WHY?

_____ _____

_____ _____

_____ _____

DENTAL HISTORY

Y N ARE YOU EXPERIENCING ANY DENTAL DISCOMFORT
Y N IS YOUR MOUTH FREQUENTLY DRY?
Y N DOES YOUR JAW BECOME SORE WITH CHEWING?
Y N DO YOUR GUMS BLEED? WHEN? _____
Y N ARE YOUR TEETH EVER SENSITIVE TO HOT/COLD/SWEET/PRESSURE
Y N DO YOU GRIND YOUR TEETH?
Y N DOES FOOD GET CAUGHT IN YOUR TEETH?
Y N DO YOU HAVE ANY OTHER DENTAL CONCERNS NOT MENTIONED? IF YES PLEASE EXPLAIN: _____

_____

ON A SCALE OF 0-10, HOW HAPPY ARE YOU WITH YOUR SMILE (10 BEING COMPLETELY HAPPY)? _____

ON A SCALE OF 0-10, HOW WOULD YOU RATE YOUR LEVEL OF DENTAL ANXIETY (10 BEING HIGHLY ANXIOUS)? _____

HAVE YOU EVER HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENT?_____

_____

PATIENT SIGNATURE_____DATE_____

DENTIST/HYGIENIST SIGNATURE_____DATE_____