# Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

## Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ (Last Name / First Name / Initial) Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

## Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

## Additional Insurance

Insured Name _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

# Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

# Medical History

Physicianís Name _____ Date of Last Visit _____

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment? | ☐ | ☐ |
| 2. Have you ever had any serious illnesses or operations? | ☐ | ☐ |
| 3. Are you currently taking any medication? | ☐ | ☐ |
| Please describe: _____ | | |
| 4. Do you smoke? | ☐ | ☐ |
| 5. Do you use alcohol, cocaine or other drugs? | ☐ | ☐ |
| 6. Do you wear contact lenses? | ☐ | ☐ |

7. Have you had any allergic reactions to the following:

| | Yes | No |
|---|---|---|
| Local Anesthetics (eg. novocaine) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates (sleeping pills) | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Other | ☐ | ☐ |

8. (Women Only) Are You:

| | | |
|---|---|---|
| Pregnant? | ☐ | ☐ |
| Nursing? | ☐ | ☐ |
| Taking birth control pills? | ☐ | ☐ |

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

# Assignment and Release

I hereby authorize payment directly to _____ for 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, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

**Cherry Lane Dental**
**1104 W. Cherry Lane**
**Meridian, Idaho 83642**
**208-888-7889**

# Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Cherry Lane Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Cherry Lane Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

| ADDITIONAL DISCLOSURE AUTHORITY | | | | |
|---|---|---|---|---|
| In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. | | | | |
| ANY MEMBER OF MY IMMEDIATE FAMILY | ☐ | YES | ☐ | NO |
| SPOUSE ONLY | ☐ | YES | ☐ | NO |
| OTHER (*PLEASE SPECIFY*): | ☐ | YES | ☐ | NO |

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

| Record of Acknowledgement not obtained | | |
|---|---|---|
| PROVIDED PRIOR TO TREATMENT? | ☐ YES ☐ NO | |
| DATE PROVIDED: | | |
| REASON FOR DENIAL: | ☐ | NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES. |
| | ☐ | WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING. |
| | ☐ | UNABLE TO SIGN. |
| | ☐ | REASON NOT GIVEN. |
| | ☐ | OTHER (EXPLAIN): |

Cherry Lane Dental

# FINANCIAL POLICY

**Payment Policy -** All deductibles, co-payments, and patient responsibility payments are due at the time of service. There is a $25.00 service charge on returned checks

**Insurance -** We are happy to bill your insurance as a courtesy to you if provided all current insurance information. While we do our best to get a general breakdown of insurance policies, it is up to the patient to know their own policy. Please be aware that some or all of the services provided may not be covered benefits.

Our fees are based on what is usual and customary for the area. You are ultimately responsible for any charges incurred regardless of what your insurance covers or determines "usual and customary".

**Minors -** Treatment may be denied without a parent/guardian present or without prior consent. The responsible adult accompanying the minor will be responsible for the payment at the time of service.

Cherry Lane Dental is not responsible to try and collect from multiple sources (i.e. divorced parents).

**No show/cancellation-** 48 hours notice is required to cancel any scheduled appointment. If required notice is not given, Cherry Lane Dental reserves the right to charge the patient or responsible party a $25.00 fee per occurrence. Upon third violation of the policy, dismissal from our practice may occur.

**Interest -** We reserve the right to charge interest in the 1% per month beginning 90 days from the date or service billing.

**Collections-** In the event that ***DEBTOR*** becomes delinquent and payment is not made on amounts owing under the terms of this agreement, and the balance is placed within a licensed collection agency, ***DEBTOR*** agrees to pay the fees of the collection agency, which amount is theretofore agreed to be 50% of the outstanding balance at the time the account is placed for collections. The 50% collection agency fee will be calculated and added at the time the account is placed into collections.

I have read and understand this financial policy. I agree to terms and conditions above.

**Responsible party (printed)** _____

**Responsible party (signed)** _____

**Patient name if different** _____ **date** _____

# Records Release/Request

To _____
(Doctor/Hospital)

Address_____

City_____State_____Zip_____

I hereby authorize the release of my:

X-rays Perio Charting Full Dental Records

or copies of such and request that they be transferred to:

Cherry Lane Dental
John Bergloff, D.D.S.
1104 W. Cherry Lane
Meridian, ID 83642
Telephone: (208)888-7889

_____
Print Name of Patient

_____
Patient's Signature Date