All Seasons Dental — Patient Information

F. Alan Walker, DMD

10233 W. Overland Rd • Boise, Id 83709 • (208)323-4700

Patient's Name: _____

Guardian **(if patient is a minor)**: _____

Date of Birth:_____ SSN: _____

Home Phone #: _____ Cell #: _____ Email: _____

Preferred Contact Method: □ Text □ Email □ Phone Call(circle one) Cell or Home

Address:_____City/State/Zip:_____

Place of Employment:_____Phone #:_____

How did you hear about us: _____

Emergency Contact:_____ Relationship: _____

Phone #:_____ Work #: _____ Ext: _____

Dental Insurance: □ Yes □ No ***if "yes" please notify receptionist and have card ready**

To our patients with insurance:

Our office is a PPO contracting provider, and we are happy to complete your insurance forms and process your dental claims with the information you provide us. However, we emphasize that our relationship as dental care providers is with you, the patient, not with your insurance company. Any money that is received on your behalf from your insurance company will be credited to your account. You should understand that you are responsible for all charges not covered by your insurance.

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize All Seasons Dental to release all information necessary to secure the payment of benefits and authorize the use of this signature for all insurance submissions.

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and my no longer be protected by HIPAA privacy regulations. **Purpose:** The photographic /video images, and/or testimonial will be used for: Social Media and/or Advertising.

Patient/Parent or Guardian Signature: _____ Date: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes. I have read and understand the financial policy to this office and that I am responsible for payment at the time of service. I have read and understand this offices appointment policy, radiograph requirements and have reviewed the Privacy Practice at All Seasons Dental.

Patient/Parent or Guardian Signature_____ Date: _____

Medical History

Patient Name:_____ Date of Birth: _____

☐ Yes ☐ No Do you like your SMILE ☺ If not, what would you change? _____

☐ Yes ☐ No 1. Are you having pain or discomfort at this time? _____

☐ Yes ☐ No 2. Are you nervous about receiving dental care? Or have had a bad experience in the past?

☐ Yes ☐ No 3. Are your gums sensitive or bleed easily when brushing?

☐ Yes ☐ No 4. Do you have a history of gum disease?

☐ Yes ☐ No 5. Do you have any lumps in or near your mouth?

☐ Yes ☐ No 6. Have you had any head, neck, or jaw injuries? Or have any problems with your jaw? If so, what? _____ _____

_____

☐ Yes ☐ No 7. Do you clench or grind your teeth?

☐ Yes ☐ No 8. Do you wear a denture, partial, or retainer?

☐ Yes ☐ No 9. **WOMEN**: Are you pregnant or nursing?

☐ Yes ☐ No Are you taking birth control pills?

- **For women taking birth control, antibiotics can decrease the effectiveness of your birth control.**

☐ Yes ☐ No 10. Have you routinely been under the care of a medical doctor during the past 5 years? If so, for what? _____ _____

_____

☐ None 11. Please list all medications you are presently taking: _____

_____

☐ None 12. ALLERGIES: Are you allergic to or made sick by Penicillin, Aspirin/Ibuprofen, Codeine, Latex, Local Anesthetic, Sulfa or any other drugs or medications? If so, what? _____ _____

_____

Check any of the following which you have had or have at present: ☐ None

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Shortness of Breath
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Swelling (Feet or Ankles)
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tobacco Habit
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tonsillitis
☐ Chemotherapy	☐ Heart Problems	☐ Recreational Drug Use	☐ Tuberculosis
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Ulcer

Please list any disease, condition, or special need not listed above: _____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient: _____ Date: _____

(or parent of legal guardian if patient is a minor)

Signature of Doctor: _____ Date: _____

Authorization for Release of Information

Patient's Name: _____

Date of Birth: _____

I, _____ , authorize All Seasons Dental to release the following information:

_____.

To (name and title of person or organization to which disclosure is to be made):

_____.

_____.

I may revoke this authorization in writing at any time, except for information which has already been released in accordance with this authorization prior to my revocation.

Signature: _____. Date: _____.

Witness: _____. Date: _____.