WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer / Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Treatment
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease / Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ **Yes** ☐ **No**

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

1323 Michigan Street, Sandpoint, ID 83864
Phone: (208) 265-1705 Fax: (208) 265-1795

Financial Agreement

Thank you for trusting us with your dental health. Our mission at Mountain Lake Dental is to deliver the finest care possible, to every patient, at reasonable rates. Our promise is to do our best to meet the needs of each of our patients. For this service, prompt payment is expected and appreciated. Please carefully review and sign our office's financial policy which is outlined below.

- Full payment is expected at the time of service. We accept cash, checks, Visa/MasterCard, Discover, and Care Credit.
- We will submit insurance claims; however, you are responsible for any deductible, co-insurance, or non-covered benefits identified by your plan.
- If you are unable to pay in full at the time of service, payment arrangements must be made in advance.
- Failure to show or cancel 24 hrs in advance for a scheduled appointment will carry a $25.00 failed appointment charge.
- There will be a $35.00 fee on returned checks.
- A late fee may incur to any past due balance over 60 days.
- In case of default, I agree to pay reasonable costs, up to fifty percent of account balance, for collection including arbitration costs, attorney fees, court costs, etc.

I have read and agree to the financial policy of Mountain Lake Dental as outlined above.

Name (Print): _____

Signature: _____

Date: _____

1323 Michigan Street, Sandpoint, ID 83864
Office: (208) 265-1705 Fax: (208) 265-1795

Acknowledgement of Receipt of Notice

As required by the Privacy Regulations, I herby acknowledge that I have been offered a copy and have had the "Notice of Privacy Practices" explained to me to my satisfaction.

As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Name (print): _____ Date: _____

Signature: _____

I authorize Dr. Ty Corbridge and/or the staff of Mountain Lake Dental to discuss my dental health, treatment needs, and/or treatment costs with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

(Office Use Only)

Signed form received by: _____ Date: _____