New Horizon Dental

1411 Fillmore St. Suite 602
Twin Falls, ID 83301
(208)733-0494

Today's Date _____ Home Phone #_____

Cell Phone #_____

Email Address_____

SS#_____

Name_____ Preferred Name_____

Mailing Address_____ City_____ State_____ Zip_____

Gender_____ Age_____ Birthdate_____ Marital Status_____

Occupation_____ Employer_____

Person Responsible for Acount_____

Relationship to Patient_____ Phone #_____

Mailing Address_____ City_____ State_____ Zip_____

Spouse's Name_____ Birthdate_____ SS#_____

Occupation_____ Employer_____

Dental Insurance _____

Subscriber's Name_____ Member ID or SS#_____

Subscriber's Date of Birth_____ Group #_____

Claim's Address_____ Phone #_____

Whom may we notify in case of emergency?_____ Phone #_____

Relationship to Patient_____

Whom may we thank for referring you?_____

Reason for today's visit?_____

Previous Dentist_____ Phone #_____

Date of last Dental care_____ Date of last Dental X-Rays_____

Are you currently under the care of a Physician? YES NO

If Yes, Please explain_____

Name of Physician_____ Phone#_____

How often do you brush?_____How often do you floss?_____

If you could change anything about your smile, what would it be?

Have you ever had an serious/difficult problems associated with any dental treatment? YES NO

Current Dental health is: Good Fair Poor

Type of toothbrush you use: Hard Med Soft

TURN OVER

Please (✓) if you have had any of the following:

_____Bad breath
_____Bleeding gums
_____Clicking or popping jaw
_____Cold sores
_____Food collection between teeth
_____Grinding teeth
_____Loose teeth or broken fillings
_____Periodontal Treatment
_____Sensitivity to cold
_____Sensitivity to heat
_____Sensitivity to sweets
_____Sensitivity when biting
_____Sores or growths in mouth

Are you currently in pain? YES NO Explain:_____

Please (✓) if you have had any of the following:

_____Anemia
_____Arthritis, Type_____
_____Artificial Heart Valves
_____Asthma
_____Artificial Joints (knee, hip, Shoulder)
_____Autism
_____Back Problems
_____Bleeding Disorder
_____Cancer, Type_____
_____Chemotherapy/Radiation
_____Circulatory Problems
_____Cough, Persistent
_____Coughing up Blood
_____Diabetes, Last A1C?_____
_____Epilepsy
_____Fainting
_____Heart Murmur
_____Heart Problems
_____Hepatitis A B C
_____High Blood Pressure
_____High Cholesterol
_____HIV Positive
_____Jaw Pain
_____Kidney Disease
_____Liver Disease
_____Low Blood Pressure
_____Memory Loss
_____Mitral Valve Prolapse
_____Nervous Problems
_____Pacemaker
_____Pre-Med for Dental Care
_____Psychiatric Care
_____Respiratory Disease
_____Rheumatic Fever
_____Scarlet Fever
_____Stroke
_____Swelling of Feet/Ankles
_____Thyroid Problems
_____Tobacco/Vaping Habits
_____Tuberculosis
_____Ulcer
Other_____

Please list ALL prescriptions, over the counter medications & supplements you are taking:_____

_____

_____

Are you allergic to any of the following:

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Other_____
Y N Latex
Y N Codeine
Y N Tetracycline

Are you or have you ever taken a Bisphosphonate for Osteoporosis? (i.e. Fosamax, Boniva, Zometa) Y N

For Women only:

Are you taking birth control? NO YES

Are you Pregnant? NO YES Week#_____

NOTES:_____

I understand that the information I have given today is correct to the best of my knowledge, I also understand that the information will be held in the strictest confidence and it is my responsibility to inform this office of any changes to my medical status. I authorize New Horizon Dental to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment. I hereby assign benefits payable, if any, to New Horizon Dental. I also give consent for x-rays and dental records to be released to insurance companies if needed. I understand that payment is due at time of service unless prior arrangements have been approved.

_____

Signature Date

NEW HORIZON DENTAL
PATIENT FINANCIAL AGREEMENT

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you. Any deductible or estimated co-payment amount will be due at the time of treatment.

If you currently ***do not have dental insurance*** you may qualify for one of the following:

1. 10% (Cash/Check) discount if treatment is paid in full at time of service
2. 5% (Debit/Credit Card) discount if treatment is paid in full at time of service
3. New Horizon Dental Discount Plan – Ask front office more information
4. In-Office Financing Program: This program requires a 50% down payment for the total cost of treatment paid on or before the date of service. The remaining 50% balance can be set up on a payment plan with a finance charge of 2.5%.
5. Cherry – Subject to approval
6. Care Credit – Subject to credit approval.

Payment is due at the time services are rendered. For your convenience we accept checks, Visa, MasterCard, Discover, money orders and cash.

Emergency clients, new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.

Returned checks will be charged a $25.00 fee. Past due balances will be subject to a monthly finance charge of 2.5%. Appointments cancelled or rescheduled without 24 hours' notice, may be subject to $40.00 late cancellation fee.

A copy of this agreement is available upon request. Please do not hesitate to ask if you have any further questions regarding this financial agreement. We are committed to helping you achieve your optimal oral health.

_____ _____

Signature of Patient or Responsible Party Relationship to Patient

_____ _____

Print Patient's Name Date

TURN OVER

NEW HORIZON DENTAL
HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

May we call and leave a detailed voicemail regarding your appointments and dental care? **YES NO**

May we text you regarding your appointments and dental care? **YES NO**

(By checking YES, you agree to receive text messages and updates from New Horizon Dental regarding your appointments and dental care. Standard message and data rates may apply. To opt out, reply 'STOP' to any text message.)

May we discuss your dental conditions with any member of your family? **YES NO**

If YES, please name the family members allowed: _____

_____

_____ _____

Signature of Patient or Responsible Party Relationship to Patient

_____ _____

Print Patient's Name Date

PLEASE FILL OUT THIS FORM IF YOU HAVE HAD X-RAYS TAKEN WITHIN THE LAST YEAR

New Horizon Dental, PLLC
Daniel Wood, DMD
1411 Fillmore St., Suite 602
Twin Falls, ID 83301
newhorizondental1@gmail.com
208-733-0494

Date: _____

Previous Dentist/Office Information: _____

Name of Patient: _____ Patient Date of Birth: _____

Please send copies of:
BWX and PA's taken within the last 2 years.
FMX and/or Pano taken within 5 years.
Perio Charting done within the last 12 months.
List of Treatment History.

To the office listed below:

New Horizon Dental, PLLC
Daniel Wood, DMD
1411 Fillmore St., Suite 602
Twin Falls, ID 83301
208-733-0494
newhorizondental1@gmail.com

Signed: _____
(Patient or Guardian)

_____
(Relationship to Patient)