New Horizon Dental

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

Today's Date _____ Home Phone # _____

Cell Phone # _____

Email Address _____

Name _____ SS#_____

Mailing Address_____ City_____ State_____ Zip_____

☐ Male ☐ Female Age _____ Birthdate _____ Marital Status _____

Occupation: _____ Employer_____

Spouse's Name _____ Birthdate _____ SS#_____

Occupation: _____ Employer_____

Person Responsible for Account _____

Date of Birth _____ Relationship to Patient _____

Address _____ City_____ State_____ Zip _____

Dental Insurance_____

Subscriber's Name_____ Member ID or SSN _____

Subscriber's Date of Birth: _____ Group # _____

Claims Address _____ Phone # _____

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

Relationship to Patient_____

Whom may we thank for you referring you?_____

Reason for today's visit?_____

Previous Dentist_____ Phone # _____

Date of last Dental care_____ Date of Last Dental X-rays_____

Personal Physician_____Phone # _____

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

If Yes, please explain:_____

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

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

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

Current Dental health is: Poor Fair Good

Type of toothbrush you use: Hard Med Soft

Please check (✓) 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? NO YES Explain:_____

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

____Anemia
____Arthritis, Rheumatoid
____ Artificial Heart Valves
____Asthma
____Artificial Joints (knee, hip, shoulder)
____Back Problems
____Bleeding Disorder
____Cancer
____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
____HIV Positive
____Jaw Pain
____Kidney Disease
____Liver Disease
____Low Blood Pressure
____Mitral Valve Prolapse
____Nervous Problems
____Pacemaker
____Pre-Med for Dental Cleanings
____Psychiatric Care
____Respiratory Disease
____Rheumatic Fever
____Scarlet Fever
____Stroke
____Swelling of feet/ankles
____Thyroid Problems
____Tobacco Habits
____Tuberculosis
____Ulcer
Other_____

Please list ALL prescriptions/over the counter drugs you are taking:_____

_____

Are you allergic to any of the following:

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Latex
Y N Codeine
Y N Tetracycline
Y N Other: _____

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 pills? _____ 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 this 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 payment is due at time of treatment, unless prior arrangements have been approved.

_____

Signature Date

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

Patient Financial Agreement

This agreement is to inform you of your financial responsibilities to our practice. Please understand that payment of your bill is considered a commitment to your dental treatment.

All charges you incur are your responsibility regardless of insurance coverage or benefit plan that may assist you in completing your treatment plan or care. We are committed to maintaining our relationship with you. As a courtesy to you, we can assist you with filing a claim so you can receive your reimbursements from your insurance company. Please remember to provide us with a copy of your current insurance card.

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

1. 10% (cash/check) discount when treatments are paid in full on or before the date of service
2. 5% (credit/debit card) discount when treatments are paid in full on or before date of service
3. In-Office Financing Program: This program requires a 50% down payment for the total cost of the treatment plan to be paid on or before the date of service. The remainder 50% balance can be set up on a payment plan with a finance charge of 2.5%.
4. Care Credit-Subject to credit approval. Can be applied for in office.

Payment is due prior to or on the day treatment is provided. Our practice accepts cash, personal checks, debit cards and Visa or MasterCard. Care Credit financing is also available upon request and credit approval.

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 without 24 hours' notice, may be subject to a $40 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.

_____
(Print Patient/Responsible Party Name)

_____ _____
(Signature of Patient/Responsible Party) (Date)

TURN OVER

New Horizon Dental, PLLC

Daniel Wood, DMD

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Twin Falls, ID 83301
newhorizondental1@gmail.com
208-733-0494

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that:

1. I am either the patient or person legally responsible for the patient.
2. I have received a copy of the "Notice of Privacy Practices".
3. I understand that I may contact New Horizon Dental, PLLC if I have any questions regarding the "Notice of Privacy Practices".

_____ _____

Patient/Responsible Party Signature Date

_____

Relationship to the Patient

To Be Completed By Staff Member

Staff member sought but was unable to obtain an acknowledgement from the patient or person legally responsible for the patient for the following reason:

_____ Patient or person legally responsible for the patient refused to sign this form.

_____ Other _____

_____

_____ _____

Staff Member's Signature Date

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this "Notice" about our privacy practice, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this "Notice" while it in effect. This "Notice" takes effect **April 14, 2003,** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this "Notice" at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our "Notice" effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this "Notice" and make the new "Notice" available upon request.

You may request a copy of our "Notice" at any time. For more information about our privacy practices, or for additional copies of this "Notice", please contact us using the information listed at the end of this "Notice".

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operation for example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operation. Healthcare operations include quality assessment and improvement activities. Reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment of healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by you authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the "Notice".
To Your Family and Friends: We must disclose your health information to you, as described in the "Patient Rights" section of this "Notice". We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provided you with an opportunity to object to such uses or disclosures. In the event if your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counter intelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters or text messages, email).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format your request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this "Notice". We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. It you request copies we will charge you $.25 for each page, plus $25.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request and alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this "Notice" for a full explanation of our fee structure.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on your use or disclosure of your health information. We are not required to agree to these additional restriction, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice: If you receive this "Notice" on our web site or by electronic mail (email) you are entitled to receive this "Notice" in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, or in response to a request your made to amend, or restrict the use, or disclosure of your health information, or to have us communicate with you by alternative means, or at alternative locations, you may complain to us using the contact information listed at the end of this "Notice". You also may submit a written complaint to the U.S. Department of Health and Human Services.
Contact Officer: Daniel Wood, DMD
Telephone: 208-733-0494 Fax: 208-733-2713
Email: newhorizondental1@gmail.com
Address: 1411 Fillmore St., Ste. 602, Twin Falls, ID 83301