PERSONAL INFORMATION
DOWNTOWN DENTAL

Last name: _____ First Name: _____

Middle Initial: _____ Preferred name to be called: _____

Circle: Male/Female Circle: Married/Single/Other Referred By: _____

Birth date: _____/ _____/_____

Social security number: _____ ---_____---_____ Driver's license Number: _____

Mailing Address: _____

_____

Email address: _____

How would you like to receive your appointment reminders? (Circle all that apply) Postcard/Email/Text

How would you like to receive your billing statements? (Circle all that apply) Mail/Email

Please list all phone numbers and circle the phone number that we can best reach you at.

Home: _____

Work: _____

Mobile: _____ May we text appointment reminders? Yes No

Employer: _____ Employer Phone: _____

Employer Address: _____

_____

Guarantor of the account (Person responsible for payment, if different from above.):

Name _____SS#_____

Address _____

Phone number_____ Relationship to patient_____

HEALTH HISTORY
DOWNTOWN DENTAL

Patient Name: _____Date:_____
Circle any of the following which you have had in the past or presently have:

Heart failure	Rash
Heart disease	Hives
Angina pectoris	Swelling
High blood pressure	Glaucoma
Heart murmur	Diabetes
Rheumatic fever – Strep. A infection	
*Congenital heart lesions	Arthritis
*Prosthetic cardiac valve	
*Cardiac transplantation	Jaw pain
*Previous endocarditis	Artificial joints
Scarlet fever	Cortisone medicine
Heart surgery	Rheumatism
High cholesterol	Joint replacements
Heart pacemaker	
Emphysema	Ulcers
Chronic cough	IBS – Irritable bowel syndrome
Tuberculosis (TB)	
Asthma	Thyroid disease
Hay fever	
Sinus trouble	Stroke
	Anemia
Kidney disease	Sickle cell disease
	Bruise easily
Cancer	Blood transfusion
Radiation therapy	Hemophilia
Chemotherapy	
	HIV positive test
Liver disease	AIDS
Hepatitis A (infectious)	Venereal disease
Hepatitis B (serum)	Genital herpes
Hepatitis C	Cold sores
	Pregnant/ how far along -
Drug addiction	Epilepsy
Psychiatric treatment	Seizures
Anxiety	Fainting spells
Latex allergy	Bisphosphonate therapy
Allergy to anesthetic	Osteopenic / Osteoporosis

Date: _____

Patient Name: _____

Please name your physician: _____

Last blood work exam: _____

Where does he/she practice: _____

What is their phone number: _____

Are you currently taking any prescribed medications? (Please list all) (If none, please write "none")

_____

_____

Are you allergic to any medication? (Please list all) (If none, please write "none")

_____

_____

Are you subject to prolonged bleeding?	Yes No
Do you use tobacco?	Yes No
Are you pregnant?	Yes No
Have you had problems with previous dental treatment?	Yes No
Do you gag easily?	Yes No
Do your gums bleed when you brush?	Yes No
Do your gums bleed when you floss?	Yes No
Are your teeth sensitive to hot or cold?	Yes No
Are you dissatisfied with the appearance of your teeth?	Yes No
How often do you brush per day?	1x 2x 3x _____
How often do you floss per week?	1x 2x 3x _____

Please list any other medical conditions not mentioned on this form that Dr. Kowalczyk should know about:

_____

_____

INSURANCE INFORMATION
DOWNTOWN DENTAL

Primary insurance

Carrier/Insurance Company: _____

Subscriber/Policy holder: _____

Subscriber ID or SS#: _____

Group #: _____

Subscriber's birth date _____ / _____ / _____

Release of information

I authorize release of any information required by my insurance carrier

Signature _____

Release of payment (Assignments of benefits):

I authorize my insurance benefits to be paid directly to Downtown Dental*

Signature _____

*Please note: If not signed, you will be expected to pay for all dental services the day they are rendered. Insurance will then reimburse you after we file your claim.

Relationship to subscriber (Circle one)

- Self
- Spouse
- Child
- Other

PLEASE INCLUDE A FRONT AND BACK COPY OF YOUR CURRENT INSURANCE CARD

HIPAA FORM
DOWNTOWN DENTAL

In accordance with HIP AA, we are legally obligated to have your written permission before we can disclose any health care information concerning you or your children to any other party.

CONSENT FOR USE AND DISCLOSURE OF HEALTHCARE INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our privacy notice carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our "Notice of Privacy Practices" sheet. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office personnel. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

ACCEPTANCE OF CONSENT:
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____

Date: _____

If this Consent is *signed by a personal representative on behalf of the patient, complete the following:*

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT:
I revoke my Consent for your use and disclosure of my protected health Information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any action you take in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: _____

Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES DOWNTOWN DENTAL

You may refuse to sign this acknowledgement.

The Privacy Policy is posted on the website.

I, _____, have received a copy of this office's

Notice of Privacy Practices on behalf of myself and my minor children, as listed:

_____

_____

_____

Signature: _____

Date: _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please specify): _____

FINANCIAL POLICY
CANCELLATION POLICY
DOWNTOWN DENTAL

Welcome! Thank you for choosing us as your healthcare provider. Our main concern is that you receive optimal dental care. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor. If you should have any questions regarding our payment policy, please do not hesitate to contact our office staff.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, Discover, American Express, ATM cards and debit cards. For some cases we do offer financing through Care Credit. We will be happy to help you process your application and your insurance claim for your reimbursement as long as you bring the required information to each visit.

Our financial policy is as follows:

1. Payment for services is due in full at the time of treatment including any co-payments that are estimated.

2. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not your insurance company.

3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

5. If the insurance company does not pay after 60 days, we require you to pay the balance due with cash, check, or credit card.

6. Returned checks will be subject to additional fees. $20 fee is the state of Idaho's maximum fee. This is what we will charge.

7. All balances over 90 days will be reviewed and possibly turned over to an agency for payment or will be sent to our Legal Counsel. You will be responsible for any additional charges incurred. A finance charge of 18% will be added to your outstanding balance if left unpaid over 90 days. This charge will be added for each 30 days past 90 days if left unpaid.

8. If you need to cancel or reschedule your appointment, we ask for 48 hour notice. If you fail to show up to your scheduled appointment time, we reserve the right to charge a $30 fee. If this happens three times, you will be dismissed from our dental practice and you will be referred to a different dentist.

We understand that temporary financial issues may affect timely payment of your account. We encourage you to communicate any such problems so that we may assist you in the management of your account. By signing below, you agree to this Financial Policy stated above.

Patient Signature: _____ Date: _____