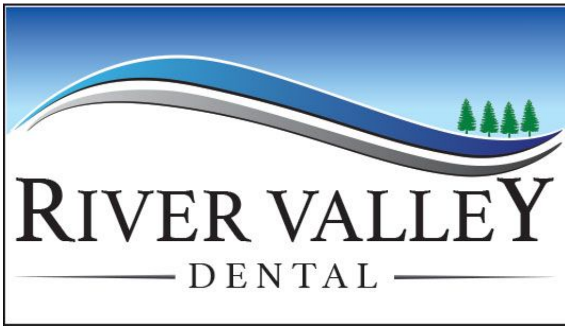

WELCOME!

How Did You Hear About Us?

☐Yellow Pages ☐Insurance List of Providers
☐Internet site ☐ Saw Our Location
☐Other Advertising
☐Family/Friend Name:

Today's Date:___________

Patient's Name: ____________________________
Birthdate: ________ Age: ___________
Social Security #_________________________
Mailing Address: _________________________
City:______ State:_____ Zip:_________
☐ Single ☐Married ☐Divorced
☐ Widowed ☐Separated ☐Child
Home Phone:_______________________________
Cell Phone:________________________________
Email Address:

Employer (if applicable) :_____________________
Employer Address:_____________________________
Employer Phone: _______________________________
How Long There? Years:____ Months:_____
Occupation:_________________________________

Name and address of closest relative not living with you

Name: _____________________________________
Address: ___________________________________
City: ______ State:______ Zip:________
Phone Number: __________________________

If patient is under the age of 18, please fill out the following:

Responsible Party/GUARANTOR

(Please Note: for children/dependents, the accompanying guardian IS the responsible party/guarantor signing for all charges for them)

Name: ____
Relationship to Patient: ___________________________
Address: ____
City: ________ State: ____Zip:_________
SS # _____________ Birthdate ________________
Home Phone: _________________________
Work Phone: __________________________
Cell Phone: ____________________________

Dr. Bryce D. Hanson

371 W. Fir Street
PO Box 525
Shelley ID 83274
(208)357-7611

Date of Last Dental Visit _______________________
Name of Last Dental Provider: __________________
Name of Physician:____________________________
Emergency Contact Name:______________________
Emergency Contact Phone # ____________________

DENTAL INSURANCE

If you have dental insurance, we are happy to bill on your behalf for any treatment received by River Valley Dental Care. However, you will be expected to pay at the time of service any ESTIMATED portion such as copays, coinsurance or deductibles including any charges not covered by insurance. If you are not able to pay your ESTIMATED portion, you must make arrangements PRIOR to receiving treatment. You are responsible to notify us immediately if your insurance information changes. Any claims not paid after 90 days of submitting them become your sole responsibility.

Primary Insurance

Name of Insurance:____________________________
Address to send Claims to: _____________________
City:______ State:_______ Zip:_________
Customer service Phone #________________________
Group Number:___________________________________
Subscriber/Member ID # __________________________
Subscriber's Name: _______________________________
Subscriber's Birthdate :___________________________
Subscriber's Social Security # _____________________
Employer:_______________________________________

Secondary Insurance

Name of Insurance: ______________________________
Address to send Claims to:_________________________
City:________ State:______ Zip:_______
Customer service Phone # _________________________
Group Number: __________________________________
Subscriber/Member ID #___________________________
Subscriber's Name: ______________________________
Subscriber's Birthdate:___________________________
Subscriber's Social Security # _____________________
Employer:______________________________________

Dental and Medical History

Please answer the following questions

Do you have or have you had:	Yes	No
1. Pain or discomfort in the mouth, face or jaws?	☐	☐
2. Bleeding or sensitive gums?	☐	☐
3. Aching or sensitive teeth?	☐	☐
4. Injury to your face or jaw?	☐	☐
5. Serious trouble associated with any previous dental treatment?	☐	☐
6. Do you feel nervous about dental treatment?	☐	☐
7. Have you been hospitalized in the last 2 years?	☐	☐
8. Do you use tobacco products?	☐	☐
9. Do you use alcoholic beverages?	☐	☐
10. Do you use recreational or street drugs?	☐	☐
11. Do you have allergies (i.e. itching, rash, swelling to metals, latex, aspirin, penicillin, codeine, or any drugs foods, or medications?	☐	☐
12. High/low blood pressure?	☐	☐
13. Heart disease, heart attack, stroke, chest pain, congenital heart defect, fast or irregular heartbeat?	☐	☐
14. Rheumatic fever or Scarlet fever?	☐	☐
15. Artificial heart valve, pacemaker, or artificial joints?	☐	☐
16. Do you need premedication prior to dental treatment due to a heart condition or prosthesis?	☐	☐
17. Tuberculosis, AIDS or HIV, venereal disease?	☐	☐
18. Anemia, Hemophilia, or other blood disease?	☐	☐
19. Breathing difficulties, asthma, emphysema, hay fever or sinus trouble?	☐	☐
20. Diabetes/low or high blood sugar?	☐	☐
21. Thyroid disease (low or high hormone levels)?	☐	☐
22. Stomach problems, ulcers, or irritable bowel?	☐	☐
23. Liver disease, hepatitis, kidney disease or dialysis?	☐	☐
24. Cancer, tumors, radiation or chemotherapy?	☐	☐

25. Are you currently taking any prescription medications? .... ☐Yes ☐No

If yes please list the following:

Name of Drug	Frequency/Amount	Reason

26. Please list any serious medical conditions you have experienced:

Women Only

27. Are you currently pregnant? ☐Yes ☐No

If yes, what is your expected due date? _________

28. Are you currently taking a prescription contraceptive? ☐Yes ☐No

Financial Policy

Please read the following carefully

I understand that this information 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 any changes in my medical status.

I hereby authorize River Valley Dental Care to perform the designated procedures and consent to all dental treatment indicated by sound procedures and consent to all dental treatment as indicated by sound prudent dental practices.

If the use of premedication and/or anesthetics is indicated, I consent to the administration of such as the doctors may deem advisable and proper.

MISSED/CANCELLED/LATE APPOINTMENTS

I understand that each patient is allowed to cancel within 24 hours or miss 2 appointments per calendar year without incurring a fee. Any further canceled or missed appointments beyond 2 per calendar year will result in a charge of $35 for each appointment missed/canceled. I also understand that if I am late 10 minutes or more and my appointment must be rescheduled, it will be considered a missed appointment and will apply to above mentioned guidelines.

FINANCIAL RESPONSIBILITY

By signing my name below as the Patient and/or GUARANTOR, I accept full responsibility for payment of services rendered. I understand that I will be charged interest on all accounts that are 90 days in age at 1.5% per month (18% APR). I agree to pay all LATE FEES ($35) COLLECTION COSTS(30% of the account balance), INCLUDING REASONABLE ATTORNEY FEES AND COURT COSTS if my account becomes delinquent.

PATIENT/GUARANTOR SIGNATURE DATE

(to be signed upon check in at our office)