Dr. Gregory Davis, DDS
467 S Rivershore Lane, Eagle ID 83616
EagleRivershoreDental.com
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PATIENT INFORMATION

Patient's Full Name: _____ DOB: _____ Age: _____ Date: _____

Gender: _____ SS#: _____ If Student, Name of School or College: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Home ☐ Cell ☐ Work ☐ Email: _____

Check appropriate box: ☐ Minor ☐ Single ☐ Divorced ☐ Widowed ☐ Married Spouse's Name: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

How did you hear about our office: _____

If by referral, who may we thank? _____

RESPONSIBLE PARTY

Name of Responsible Party for this Account: _____ DOB: _____ Age: _____

Relationship to Patient: _____ Driver's License #: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Home ☐ Cell ☐ Work ☐ Email: _____

Are you a current Patient of our Practice? ☐ Yes ☐ No

We offer the following methods of payment. Please check the option you prefer. **Full Payment of rendered service, will be required at the end of every appointment**. ☐ Cash ☐ Check ☐ Care Credit® ☐ Credit Card: ☐ VISA ☐ MasterCard
☐ I wish to discuss the office's payment policy.

INSURANCE INFORMATION – Please give your cards to the front desk (for scanning).

Primary Insurance: _____ Employer: _____

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____

SS#: _____ ID Number: _____ Group Number: _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No If yes, complete the following:

Primary Insurance: _____ Employer: _____

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____

SS#: _____ ID Number: _____ Group Number: _____

PATIENT MEDICAL HISTORY

Please Answer the Following:

Are you under a physician's care now? ☐ Yes ☐ No If yes, Who? _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

If Yes, please list them: _____

Do you, have you taken, Phen-fen or Redux? ☐ Yes ☐ No If yes, how long: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use Tobacco? ☐ Yes (If Yes, ☐ Cigarettes ☐ Chewing Tobacco) ☐ No

Are you Allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you have any other allergies? ☐ Yes ☐ No If yes, please list: _____

Do you use controlled substance? ☐ Yes ☐ No If yes, please list: _____

Please Check all that apply to you.

Do you have or have you had, any of the following?

Aids/HIV Positive	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Cancer, _____	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Diabetes, _____	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No			

Have you ever had a serious illness that is not listed? _____

Woman: Are you... ☐ Pregnant/Trying to get Pregnant ☐ Nursing ☐ Taking oral contraceptives

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes ☐ No
4. Do you feel pain in any of your teeth? ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
7. Have you ever experienced any of the following problems in your jaw? ☐ Yes ☐ No

If Yes, please check all that apply...

- ☐ Jaw clicking
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty in opening or closing mouth/jaw
- ☐ Difficulty in chewing

8. Do you have frequent headaches? ☐ Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes ☐ No
10. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
11. Have you ever had any difficult extractions in the past? ☐ Yes ☐ No
12. Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No
13. Have you had any orthodontic treatment? ☐ Yes ☐ No
14. Do you wear dentures or partials? ☐ Yes ☐ No If Yes, date of placement: _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes ☐ No
16. Do you like your smile? ☐ Yes ☐ No If No, what would make it better: _____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

SIGNATURE of Patient, Guardian or Personal Representative (your relationship to Patient) Date

AUTHORIZATION & RELEASE

- I understand and acknowledge that all questions have been accurately answered and that providing incorrect information can be dangerous to my health.
- I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care and/or healthcare practitioners.
- I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay lass than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I acknowledge that payment is due at the time of treatment unless other arrangements have been made. I understand that I will be assessed a 22% annual finance charge on any balance over 60 days.
- I acknowledge that if I do not give 48 hours' notice of a cancellation I will be charged a $50 no show fee.
- I acknowledge that if I have a check returned for non-sufficient funds that I would be charged $25 for that returned check.

_____ _____

SIGNATURE of Patient, Guardian or Personal Representative (your relationship to Patient) Date

PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement*

I _____ have received a copy of this office's **Notice of Privacy Practices**.

_____ _____

SIGNATURE of Patient, Guardian or Personal Representative (your relationship to Patient) Date

FINANCIAL AGREEMENT

We the undersigned, individually and as agent for the patient, understand and agree, jointly and severally, to the following:

1. That if this account is sent to collections, we agree that in addition to any amount left owing to Eagle Rivershore dental we will be responsible for interest at a rate of 22% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.
2. That we specifically authorize Eagle Rivershore Dental or any assignee thereof, to access our credit file should this account become delinquent. We recognize that insurance is a contract between the patient and insurance company, and agree to pay all charges under this agreement regardless of any insurance coverage. This agreement shall apply to any unpaid services owed to Eagle Rivershore Dental in writing that is to be revoked. We have either received or refused a copy of this agreement*. We agree that no oral agreements have been made and that this agreement cannot be modified orally.
3. That we acknowledge that Eagle Rivershore Dental, including its attorneys and assigns, may have a legitimate business purpose in calling me to discuss this account and we expressly consent that we may be contacted at any telephone number, by a live caller, and that we will bear the cost of any charges associated with such a call.
4. That we have read this agreement and understand its terms. A copy or fax of this document shall have the same legal effect as the original.

_____ _____

SIGNATURE of Patient, Guardian or Personal Representative (your relationship to Patient) Date