

# WATERS EDGE DENTAL

## Patient Information

**Patient's Name** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Marital Status  Single  Married  Divorced  Widowed  Separated  
Home Address \_\_\_\_\_ Phone (H) (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
City/State/ZIP \_\_\_\_\_ (C) (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
E-mail address \_\_\_\_\_

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_  
Business Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
City/State/ZIP \_\_\_\_\_

**Spouse/Partner Name** \_\_\_\_\_ **Spouse/Partner Employer** \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/ZIP \_\_\_\_\_ Phone # (H) \_\_\_\_\_ (C) \_\_\_\_\_

**Person Responsible for Account:** Self  Spouse/Partner  Parent   
Other (please specify)  \_\_\_\_\_

**Contact in case of dental emergency:** \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/ZIP \_\_\_\_\_ Phone # (H) \_\_\_\_\_ (C) \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_

**If Patient Is A Minor:** I hereby grant permission for dental work to be performed on this minor and will assume all responsibilities connected with such treatment.

**Signature of Parent or Guardian** \_\_\_\_\_

### DENTAL HISTORY

Name \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

<b>Please Check (✓)</b>	<b>Yes / No</b>		<b>Yes/No</b>		<b>Yes/No</b>
Sensitivity to hot/cold	<input type="checkbox"/> <input type="checkbox"/>	Cigarette/pipe/smoking	<input type="checkbox"/> <input type="checkbox"/>	Crowded teeth	<input type="checkbox"/> <input type="checkbox"/>
Gum disease	<input type="checkbox"/> <input type="checkbox"/>	(____ yrs.)		Bad breath	<input type="checkbox"/> <input type="checkbox"/>
Sore on lips or in mouth	<input type="checkbox"/> <input type="checkbox"/>	Chew tobacco	<input type="checkbox"/> <input type="checkbox"/>	Food collection	<input type="checkbox"/> <input type="checkbox"/>
Dry mouth	<input type="checkbox"/> <input type="checkbox"/>	Chew on one side only	<input type="checkbox"/> <input type="checkbox"/>	Swelling around teeth	<input type="checkbox"/> <input type="checkbox"/>
Bleeding gums	<input type="checkbox"/> <input type="checkbox"/>	Grinding teeth	<input type="checkbox"/> <input type="checkbox"/>	Broken fillings	<input type="checkbox"/> <input type="checkbox"/>
Jaw pain	<input type="checkbox"/> <input type="checkbox"/>	Mouth breathing	<input type="checkbox"/> <input type="checkbox"/>	Loose teeth	<input type="checkbox"/> <input type="checkbox"/>
Discolored teeth	<input type="checkbox"/> <input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/> <input type="checkbox"/>	Braces	<input type="checkbox"/> <input type="checkbox"/>

Are you interested in:  bleaching?  veneer?  straighter teeth?

What would you change about your smile? \_\_\_\_\_

Water's Edge Dental  
Phone (208) 375.0572

6657 Glenwood St.  
Fax (208) 272.9348

Boise, ID 83714  
www.watersgedentalboise.com

**MEDICAL HISTORY**

Name (please print) \_\_\_\_\_

Name of primary medical provider (physician): \_\_\_\_\_ phone # \_\_\_\_\_

Are you taking medication at this time?  Yes  No

If so, please list and provide dosage. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to:  Penicillin  Codeine  Dental anesthetic  Metals/other materials?

Are you susceptible to latex allergies?  Yes  No

Do you have any other allergies we should be aware of? \_\_\_\_\_

Are you pregnant or think you are pregnant?  Yes  No Estimated due date: \_\_\_/\_\_\_/\_\_\_\_\_

Are you subject to  prolonged bleeding  fainting spells  excessive urination or thirst

Have you ever had any type of radiation therapy (other than diagnostic)?  Yes  No

<b><i>Please Check (☑)</i></b>	<b><i>Yes / No</i></b>		<b><i>Yes / No</i></b>
Abnormal blood pressure	<input type="checkbox"/> <input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/> <input type="checkbox"/>
Arthritis or Rheumatism	<input type="checkbox"/> <input type="checkbox"/>	Mitral valve prolapsed	<input type="checkbox"/> <input type="checkbox"/>
Artificial joints	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis	<input type="checkbox"/> <input type="checkbox"/>
Date of surgery: ___/___/_____		HIV/AIDS	<input type="checkbox"/> <input type="checkbox"/>
Asthma or hay fever	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>
Blood disease or anemia	<input type="checkbox"/> <input type="checkbox"/>	Kidney disorder	<input type="checkbox"/> <input type="checkbox"/>
Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>	Leukemia	<input type="checkbox"/> <input type="checkbox"/>
Chronic cough	<input type="checkbox"/> <input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/> <input type="checkbox"/>
Cold sores or fever blisters	<input type="checkbox"/> <input type="checkbox"/>	Parkinson's	<input type="checkbox"/> <input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/>
Epilepsy	<input type="checkbox"/> <input type="checkbox"/>	Sinus trouble	<input type="checkbox"/> <input type="checkbox"/>
Frequent canker sores	<input type="checkbox"/> <input type="checkbox"/>	STDs	<input type="checkbox"/> <input type="checkbox"/>
Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>
Head injury	<input type="checkbox"/> <input type="checkbox"/>	Thyroid condition	<input type="checkbox"/> <input type="checkbox"/>
Heart disease	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis or lung disease	<input type="checkbox"/> <input type="checkbox"/>
Heart murmur	<input type="checkbox"/> <input type="checkbox"/>	Tumors or growths	<input type="checkbox"/> <input type="checkbox"/>
		Ulcers	<input type="checkbox"/> <input type="checkbox"/>

Any other medical problems we need to be aware of: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

## Water's Edge Dental

*\* You May Refuse to Sign This Acknowledgment\**

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

Print Name: \_\_\_\_\_

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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WATER'S EDGE DENTAL**  
Geoffrey P. Herzog, DMD, FAGD

*Request for Dental Records*

Patient's Name: \_\_\_\_\_  
Last Name                      First Name                      Middle  
\_\_\_\_\_  
Maiden/Previous Name                      Date of Birth

I hereby request and authorize:

Previous dental office: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail contact: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To be released to:  
Water's Edge Dental  
6657 N Glenwood  
Boise, ID 83714

\* Records may be emailed to: [frontoffice1@wedboise.com](mailto:frontoffice1@wedboise.com)

I acknowledge that data to be released **MAY INCLUDE** material that is protected by Federal Law and that is applicable to **ANY & ALL** of the above.

My signature below authorizes release of all such information.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date



**WATER'S EDGE DENTAL**  
Geoffrey P. Herzog, DMD, FAGD

**FINANCIAL AGREEMENT**

This agreement is to inform you of your financial obligation to Water's Edge Dental. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. All charges you incur are your responsibility regardless of your insurance coverage. If your treatment requires the use of a dental lab (crowns, bridges, partials, dentures, etc.) **50%** of your estimated fee **IS REQUIRED** on your first treatment appointment. Water's Edge Dental offers a 5% discount on services paid in full at time of service (for non-insured, cash/check paying patients). For services exceeding \$750.00 a payment plan will be required prior to the start of the dental treatment.

**Dental Insurance:** As a courtesy to you, we will be happy to complete and forward insurance forms relative to your dental treatment, and will do so at no charge. To serve and assist you in utilizing your dental insurance, Water's Edge Dental accepts assignment of benefits from your insurance company. It is your responsibility to provide us with the correct subscriber ID number and the correct mailing address of your insurance carrier. Please keep in mind that our professional treatment is rendered to you, NOT your insurance company. Therefore, ultimate responsibility for payment is yours. The determination of what benefits are allowed is a negotiation between your employer and the insurance provider. If you have any questions about the amount the insurance plan will pay or the treatments your plan will cover, you should refer these questions to your employer. At your request, this office will provide all pertinent information to your insurance company and we will do our best to help you derive the maximum benefits available.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Our practice accepts cash, personal checks, MasterCard, VISA and Discover. We also accept CareCredit and Wells Fargo Health Advantage Plan. Please ask us if you would like more information regarding these programs.

Returned checks, bank fees and balances older than 90 days will be subject to finance charges at the rate of 1.5% per month (18% annually).

**I acknowledge and agree that I may be required to pay a missed appointment fee if I have missed two or more appointments in the last twelve months. A missed appointment is considered to be one that I do not keep or do not cancel within 48 hours of its scheduled time.**

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

\_\_\_\_\_  
Print Name of Patient or Responsible Party

\_\_\_\_\_  
Signature of Patient or Responsible Party

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

