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 _____

Please Check (☑)	***Yes / No***			***Yes/No***			***Yes/No***	
Sensitivity to hot/cold	☐	☐	Cigarette/pipe/smoking (___ yrs.)	☐	☐	Crowded teeth	☐	☐
Gum disease	☐	☐				Bad breath	☐	☐
Sore on lips or in mouth	☐	☐	Chew tobacco	☐	☐	Food collection	☐	☐
Dry mouth	☐	☐	Chew on one side only	☐	☐	Swelling around teeth	☐	☐
Bleeding gums	☐	☐	Grinding teeth	☐	☐	Broken fillings	☐	☐
Jaw pain	☐	☐	Mouth breathing	☐	☐	Loose teeth	☐	☐
Discolored teeth	☐	☐	Lip or cheek biting	☐	☐	Braces	☐	☐

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

What would you change about your smile? _____

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

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

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

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 _____/_____/_____

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