# **WATERS EDGE DENTAL**

### **Patient Information**

Marital Status   Single   Married   Divorced   Widowed   Separated   Come Address   Phone (H)   Companied   Come Address   Phone (Marital Barbara Address   Phone (Marital Bar	Marital Status   Single   Married   Divorced   Widowed   Separated   Hone Address   Cl.   Spouse/Partner   Phone (H)   Cl.   Spouse/Partner   Parent   Spouse/Partner   Parent   Spouse/Partner   Parent   Statistical   Statistical   Spouse/Partner   Parent   Statistical   Statist	Marital Status ☐ Single Home Address City/State/ZIP E-mail address	e 🗌 Married	☐ Divorced ☐ Wid	P	eparated hone (H) ()	/
Phone (H) (	Phone (H)	Home Address City/State/ZIP E-mail address			P	hone (H) ()	
City/State/ZIP	Comparison   Com	City/State/ZIP E-mail address					
EmployerOccupation	Employer Occupation  Business Address   Phone   Phone	E-mail address				(C) ()	
EmployerOccupation	Employer Occupation Phone (						
Business Address	Spouse/Partner Name						
Spouse/Partner Name	Spouse/Partner Name						
Spouse/Partner Name	Spouse/Partner Name					Phone ()	
Address	Address	City/State/ZIP					
Person Responsible for Account: Self  Spouse/Partner  Parent    Other (please specify)  Phone # (H)  (C)  Contact in case of dental emergency:  Address  Phone # (H)  (C)  Contact in case of dental emergency:  Address  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	Person Responsible for Account: Self   Spouse/Partner   Parent	Spouse/Partner Name	_	Spouse	e/Partner Emplo	oyer	
Person Responsible for Account: Self	Person Responsible for Account: Self   Spouse/Partner   Parent   Dither (please specify)	Address					
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	Contact in case of dental emergency:	City/State/ZIP			Phone # (H) <sub>-</sub>	(C)	
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	Address						
Phone # (H) (C)	Phone # (H)   (C)	Contact in case of dental	emergency:				
Whom may we thank for referring you:	Please Check (ED)   Yes / No   Yes/No   Sensitivity to hot/cold   Cigarette/pipe/smoking   Crowded teeth   Gorn disease   Jyrs.)   Bad breath   Jyrs.   Jyrs.   Bad breath   Jyrs.   Jyrs	Address					
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   Cigarette/pipe/smoking   Crowded teeth   Gum disease   (	City/State/ZIP			Phone # (H) <sub>-</sub>	(C)	
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	14/1					
Signature of Parent or Guardian  DENTAL HISTORY  Name  Reason for Today's Visit	DENTAL HISTORY	,	, ,				
Name Reason for Today's Visit	Reason for Today's Visit	-			oe performed o	on this minor and will assume	e all
Reason for Today's Visit	Reason for Today's Visit    Please Check (   D   Yes	responsibilities connecte	ed with such trea	tment.			e all
	Please Check (ED) Yes / No  Sensitivity to hot/cold	responsibilities connecte Signature of Parent or Gu	ed with such trea	DENTAL HIST	ORY		e all
	Sensitivity to hot/cold	responsibilities connecte Signature of Parent or Gu	ed with such trea	DENTAL HIST	ORY		e all
РIEase Uneck (Ш)	Sensitivity to hot/cold	responsibilities connecte Signature of Parent or Gu	ed with such trea	DENTAL HIST	ORY		e all
	Gum disease	Signature of Parent or Gu	ed with such trea	DENTAL HIST	ORY		
	Ory mouth	Reason for Today's Visit	ed with such trea	DENTAL HIST	ORY  Yes/No		Yes/No
Sore on line or in mouth $\Box$ Chew tobacco $\Box$ $\Box$ Enad collection $\Box$	Bleeding gums	NameReason for Today's Visit _	ed with such trea	DENTAL HIST  Cigarette/pipe/smoking	ORY  Yes/No	Crowded teeth	Yes/No
orie offings of infinioutiff and a cliew topacco and room confection.	aw pain	Name	ed with such trea	DENTAL HIST  Cigarette/pipe/smoking (yrs.)	Yes/No	Crowded teeth Bad breath	Yes/No
Dry mouth $\Box$ $\Box$ Chew on one side only $\Box$ Swelling around teeth $\Box$	Discolored teeth	Name	ed with such trea	Cigarette/pipe/smoking ( yrs.) Chew tobacco	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth	Yes/No
Dry mouth		Name	ed with such trea	Cigarette/pipe/smoking ( yrs.) Chew tobacco Chew on one side only Grinding teeth	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings	Yes/No
Ory mouth	Are you interested in: $\Box$ bleaching? $\Box$ veneer? $\Box$ straighter teeth?	Name	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only Grinding teeth Mouth breathing	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings	<i>Yes/No</i>
Ory mouth		Name	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only Grinding teeth Mouth breathing	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings Loose teeth	<i>Yes/No</i>
Dry mouth	What would you change about your smile?	Name	ed with such trea  uardian  es / No	Cigarette/pipe/smoking ( yrs.) Chew tobacco Chew on one side only Grinding teeth Mouth breathing Lip or cheek biting	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings Loose teeth Braces	<i>Yes/No</i>
	Sore on lips or in mouth	responsibilities connecte Signature of Parent or Gu Name Reason for Today's Visit	ed with such trea	DENTAL HIST	ORY		e all
Sensitivity to hot/cold $\square$ $\square$ Cigarette/pipe/smoking $\square$ $\square$ Crowded teeth $\square$ $\square$	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   Discolored teeth   Lip or cheek biting   Braces   Discolored teeth   D	responsibilities connecte Signature of Parent or Gu Name Reason for Today's Visit	ed with such trea	DENTAL HIST	ORY		
	Sore on lips or in mouth       Chew tobacco       Food collection       Ory mouth   Chew on one side only     Swelling around teeth     Bleeding gums   Grinding teeth   Broken fillings     aw pain   Mouth breathing   Loose teeth     Discolored teeth   Lip or cheek biting   Braces	Reason for Today's Visit	ed with such trea	DENTAL HIST	ORY  Yes/No		Yes/No
Gum disease $\square$ $\square$ ( $\_$ yrs.) Bad breath $\square$ $\square$	Sore on lips or in mouth	esponsibilities connecte signature of Parent or Gu Name Reason for Today's Visit _ Please Check (☑) Ye	ed with such trea	DENTAL HIST	ORY  Yes/No		Yes/No
<u> </u>	Ory mouth	Reason for Today's Visit _ Please Check (27) Yes	ed with such trea	DENTAL HIST  Cigarette/pipe/smoking	ORY  Yes/No	Crowded teeth	Yes/No
Gara on line or in mouth $\Box$ Chew tobacco $\Box$ $\Box$ Enad collection $\Box$	Ory mouth	NameReason for Today's Visit _	ed with such trea	DENTAL HIST  Cigarette/pipe/smoking	ORY  Yes/No	Crowded teeth	Yes/No
ANTE ON HIS OF IN MODITY	Bleeding gums	Name	ed with such trea	DENTAL HIST  Cigarette/pipe/smoking (yrs.)	Yes/No	Crowded teeth Bad breath	Yes/No
DOLE OFFICIAL DOLLING TO THE CONTROL OF THE TOUR CONTROL OF THE	Bleeding gums	Name	ed with such trea	DENTAL HIST  Cigarette/pipe/smoking (yrs.)	Yes/No	Crowded teeth Bad breath	Yes/No
ore of the control of	Bleeding gums	Reason for Today's Visit _ Please Check (127) Yes Sensitivity to hot/cold Gum disease	ed with such trea	DENTAL HIST  Cigarette/pipe/smoking (yrs.)	Yes/No	Crowded teeth Bad breath	Yes/No
·	aw pain	Reason for Today's Visit _ Decrease Check (2) Yestensitivity to hot/cold form disease fore on lips or in mouth	ed with such trea	Cigarette/pipe/smoking ( yrs.) Chew tobacco	Yes/No	Crowded teeth Bad breath Food collection	Yes/No
·	aw pain	Reason for Today's Visit _ Reason for Today's Visit _ Rensitivity to hot/cold form disease fore on lips or in mouth	ed with such trea	Cigarette/pipe/smoking ( yrs.) Chew tobacco	Yes/No	Crowded teeth Bad breath Food collection	Yes/No
Ory mouth $\Box$ $\Box$ Chew on one side only $\Box$ Swelling around teeth $\Box$	aw pain	Reason for Today's Visit _  Sensitivity to hot/cold  Gum disease Fore on lips or in mouth  Dry mouth	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth	<i>Yes/No</i>
Ory mouth $\Box$ $\Box$ Chew on one side only $\Box$ Swelling around teeth $\Box$	Discolored teeth	Reason for Today's Visit _  Sensitivity to hot/cold  Gum disease  Sore on lips or in mouth  Dry mouth	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth	<i>Yes/No</i>
Ory mouth $\Box$ $\Box$ Chew on one side only $\Box$ Swelling around teeth $\Box$	Discolored teeth	Reason for Today's Visit _  Sensitivity to hot/cold  Gum disease Sore on lips or in mouth Ory mouth	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth	<i>Yes/No</i>
Ory mouth $\Box$ $\Box$ Chew on one side only $\Box$ Swelling around teeth $\Box$	Discolored teeth	Reason for Today's Visit _  Sensitivity to hot/cold  Gum disease Sore on lips or in mouth Ory mouth	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth	<i>Yes/No</i>
Ory mouth	Discolored teeth	Reason for Today's Visit _ Reason for Today's Vi	ed with such trea	Cigarette/pipe/smoking ( yrs.) Chew tobacco Chew on one side only Grinding teeth	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings	Yes/No
Dry mouth		Name	ed with such trea	Cigarette/pipe/smoking ( yrs.) Chew tobacco Chew on one side only Grinding teeth	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings	Yes/No
Dry mouth		Name	ed with such trea	Cigarette/pipe/smoking ( yrs.) Chew tobacco Chew on one side only Grinding teeth	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings	Yes/No
Dry mouth	Are you interested in: ☐ bleaching? ☐ veneer? ☐ straighter teeth?	Name	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only Grinding teeth Mouth breathing	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings Loose teeth	<i>Yes/No</i>
Dry mouth	Are you interested in:	Name Reason for Today's Visit _ Sensitivity to hot/cold Gum disease Sore on lips or in mouth Dry mouth Bleeding gums Jaw pain	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only Grinding teeth Mouth breathing	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings Loose teeth	<i>Yes/No</i>
Dry mouth		Name Reason for Today's Visit _ Sensitivity to hot/cold Gum disease Sore on lips or in mouth Dry mouth Bleeding gums Jaw pain	ed with such trea	Cigarette/pipe/smoking (yrs.) Chew tobacco Chew on one side only Grinding teeth Mouth breathing	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings Loose teeth	<i>Yes/No</i>
Dry mouth		Name	ed with such trea  uardian  es / No	Cigarette/pipe/smoking ( yrs.) Chew tobacco Chew on one side only Grinding teeth Mouth breathing Lip or cheek biting	Yes/No	Crowded teeth Bad breath Food collection Swelling around teeth Broken fillings Loose teeth Braces	<i>Yes/No</i>

Water's Edge Dental Phone (208) 375.0572 6657 Glenwood St. Fax (208) 272.9348

Boise, ID 83714 www.watersedgedentalboise.com

### **MEDICAL HISTORY**

Name of primary medical pr			
rame or primary medicar pr	ovider (physician):		phone #
Are you taking medication a	it this time? $\square$ Yes	□ No	
If so, please list and provide	dosage		
Are you allergis to,  Denisi	llin	□ Dental anasthatic □ Matala	lathar matarials?
Are you allergic to: ☐ Penici			other materials?
Are you susceptible to latex	_		
		re of?	
Are you pregnant or think yo	ou are pregnant?	☐ Yes ☐ No Estimated due date	e:/
Are you subject to	prolonged bleeding	$\square$ fainting spells $\square$ excessive	ve urination or thirst
Have you ever had any type	of radiation therapy (c	other than diagnostic)? $\Box$ 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	
		STDs	
		ā. i	ПП
Frequent canker cores		Stroke	
Frequent canker cores Glaucoma			
Frequent canker cores Glaucoma Head injury		Thyroid condition	
Frequent canker cores Glaucoma Head injury Heart disease Heart murmur			

Water's Edge Dental Updated January 2016

# 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
N	/laiden/Previous Name		Date of Birth
I hereby request	and authorize:		
Previous	dental office:		
Address:			
E-mail co	ntact:		
Phone:		Fax:	
To be released to Water's E 6657 N G Boise, ID	dge Dental lenwood		
* Records may be	e emailed to: frontoffice	1@wedboise.com	
_	at data to be released <b>M</b> . <b>/ &amp; ALL</b> of the above.	AY INCLUDE material tha	at is protected by Federal Law and that is
My signature belo	ow authorizes release of	all such information.	
Signature of Patie	ent 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/	
060,02	3°00 50°°