

# MOUNTAINS WEST DENTAL

*Welcome.... We are pleased to welcome you to our clinic. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.*

## PATIENT INFORMATION

NAME \_\_\_\_\_ DATE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

PHYSICAL ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

MARTIAL STATUS \_\_\_\_\_ SPOUSE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SSN# \_\_\_\_\_ DRIVERS LICENSE \_\_\_\_\_

Name of Person responsible if PATIENT is a MINOR \_\_\_\_\_

ADDRESS (if different from above) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

RELATIONSHIP (spouse, friend, co-worker, etc.) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Policy Holder \_\_\_\_\_ SSN# \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Address \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Policy Holder \_\_\_\_\_ SSN# \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Address \_\_\_\_\_

I authorize my insurance company to pay the clinic all insurance benefits otherwise payable for services rendered.

I authorize the clinic to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No

Have you ever been hospitalized or had a major operation? Yes No

Have you ever had a serious head or neck injury? Yes No

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

If yes, list \_\_\_\_\_

Do you take or have you taken Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

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

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you pregnant or trying to get pregnant? Yes No

Nursing? Yes No

Taking oral contraceptives? Yes No

Are you allergic to any of the following?  
 \_\_\_ Aspirin \_\_\_ Penicillin \_\_\_ Codeine \_\_\_ Acrylic \_\_\_ Metals \_\_\_ Latex \_\_\_ Local Anesthetics Other \_\_\_\_\_

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

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

Comments: \_\_\_\_\_

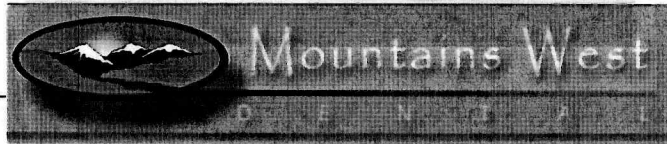
I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist and hygienist to help determine appropriate dental treatment. If there are any changes in my medical status I will inform the clinic.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Update \_\_\_\_\_ Date \_\_\_\_\_

Update \_\_\_\_\_ Date \_\_\_\_\_

Update \_\_\_\_\_ Date \_\_\_\_\_



## 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.

\_\_\_\_\_  
Please Print Name

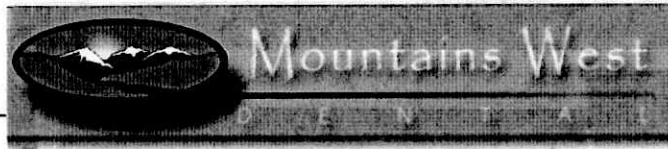
\_\_\_\_\_  
Signature

\_\_\_\_\_  
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)



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# NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4 / 14 / 03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.00 for each page, \$ 0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: SARAH OGDEN  
Telephone: (208) 253-6077 Fax: (208) 253-6077  
E-mail: Ø  
Address: P.O. Box 572 COUNCIL, ID 83612

**Mountains West Dental  
Dr. Monte R. Eppich**

**FINANCIAL POLICY AND CONTRACT**

**Payment Options Without In-Office Financing**

1. Payment in full for today's treatment (or)
2. A "Post dated check" for the entire balance of the treatment (or)
3. Bank or finance company arranged loans (dental office may assist patient in application).

**Payment Options With In-Office Financing**

Extended payments:

Three payments each: 1/3 at first visit, 1/3 of payment 30 days after completion of treatment, and the final 1/3 of payment 60 days after completion of treatment.

*Payment must be complete before any new treatment will begin.*

**For Those Patients with Insurance**

1. Patient's estimated portion of treatment must be paid in FULL at the time of treatment.
2. Patient must pay any additional portion in FULL within 30 days after receiving the statement, noting that insurance has paid its share.
3. We must be provided with a copy of your insurance card at the time of service showing the members name, ID, and group numbers, as well as the claims address for billing. We cannot accept responsibility for collecting from the insurance company or negotiating settlement on a claim. You are ultimately responsible for your account regardless of insurance coverage.

I understand the above payment options and having selected the option that suits my financial schedule, agree to pay as described.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_