The Tooth Dome

Patient Information and Consent Form

Name____
Last First M
Address____

City_______________________**State**_____**Zip**___________

Home #____________________**Cell #**______________________

Birthdate___________________**SS #**______________________

Email Address____

Employer____

How Long?_______________**Work #**_____________________

Spouse's Name____

Spouse's Contact #_____________________________________

Nearest Relative Not Living with You

_____________________________**Phone #**_________________

Person to Contact in Case of an Emergency

_____________________________**Phone #**_________________

Who may we thank for referring you to us?

____

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor and/or his staff to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with dental treatment and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

I have read all the information on both sides/pages of this sheet and have answered all questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or information.

Patient Signature_______________________________________

Date____

Dental Insurance Information

Primary

Insurance Company_____________________________________

Employer____

Employee______________________**SS#**__________________

Employee Birthdate_________________**Group#**_____________

Secondary

Insurance Company_____________________________________

Employer____

Employee______________________**SS#**__________________

Employee Birthdate_________________**Group#**_____________

We will gladly assist you with your insurance claims with the following understanding:

*The patient has full responsibility for payment of services.
***Your insurance policy is a contract between you and your insurance company only.**
*Any quotes regarding treatment coverage or the patients deductibles and percentages to be paid are **estimated** for your convenience. These are not to be misconstrued as any type of contract between you and our office.
*We deal with a large variety of insurances and every insurance company varies in the amount of the benefits that are allowed. We cannot possibly have full knowledge of every company. **It is the patients responsibility to know specifics of their insurance coverage.**
*Please check your insurance handbook about your particular coverage.

I authorize release of any information relating to this claim and direct payment to John E. Goodrich, D.D.S. I understand that I am responsible for all costs of dental treatment.

All dental services performed must be paid for at the time of service. A service charge of 1 ½ % (18% annually) will be charged on all accounts exceeding 60 days. All balances not paid in full within 60 days will be turned over to a collection agency. If the account is sent to collections I agree to pay all attorney's fees, court costs, filing fees and all collection costs, up to 30% of the amount owing which may be assessed by any collection agency retained to pursue the matter.

Health History

Please indicate any of the following you have had or currently have

Y N **Anemia**

Y N **Angina Pectoris**

Y N **Arthritis**

Y N **Artificial Heart Valve** Date____________

Y N **Artificial Joint** Date_____________

Y N **Asthma**

Y N **Bruise Easily**

Y N **Cancer or Tumor** Date___________ Where______________

Y N **Cold Sores**

Y N **Congenital Heart Lesions**

Y N **Chronic Cough**

Y N **Diabetes** Type________

Y N **Emphysema**

Y N **Epilepsy or Seizures**

Y N **Fainting or Dizzy Spells**

Y N **Headaches**

Y N **Heart Disease or Attack** Date___________

Y N **Heart Failure** Date__________

Y N **Heart Murmur**

Y N **Heart Pacemaker**

Y N **Heart Surgery** Date__________

Y N **Hemophilia**

Y N **Hepatitis A, B or C**

Y N **High Blood Pressure**

Y N **High Cholesterol**

Y N **HIV/Aids**

Y N **Kidney Trouble**

Y N **Liver Disease**

Y N **Osteoporosis**

Y N **Pain in Jaw Joints**

Y N **Radiation or Chemotherapy** Date__________

Y N **Rheumatic Fever**

Y N **Sickle Cell Disease**

Y N **Sinus Trouble**

Y N **Stroke** Date____________

Y N **Thyroid Disease**

Y N **Tuberculosis (TB)**

Y N **Ulcers**

Y N **Yellow Jaundice**

Do you have any disease or condition not listed above?____

Are you allergic or have you reacted adversely to any medications?____

Do you have any other allergies?____

Please list all medications you are currently taking____

Y N **Do you use Tobacco products?** What type___________________________________ How much/often_______________________________

Y N **Are you interested in Cosmetic Dentistry** (Including Whitening)

Y N **Are you pregnant**

Name of regular Physician____ **Phone #**____

John E. Goodrich D.D.S.
Consent For Use And Disclosure
Of Health Information

Patient Name: ____

Address: ____

Phone: _____________________ Social Security #: _____________________

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices: You have the right to read out Notices of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office via email at goodrich@fiberpipe.net or by phone at 208-587-3314 or fax 208-587-3921 or by mailing us at P.O. Box 660, Mountain Home, Idaho 83647.
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. **Please understand that revocation of this Consent will not effect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.**

SIGNATURE

I, ______________________________ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature: ____________________________________ Date: __________________

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: ______________________________ Relationship: ______________________