2003 E. Quail Run Rd.
Emmett, Idaho 83617
208.365.3534

Dr. Darren Wallace, D.M.D. &
Dr. Andrea Wallace, D.M.D.

PATIENT INFORMATION

Today's Date ____/____/____ Birth Date ____/____/____ Patient Social Security # ____-____-____

First Name ____________ Last Name ____________ Middle Initial ____

Street Address ____________

City, State, Zip ____________

Home Phone ____________ Cell ____________ Work ____________

☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced

Employer ____________ Occupation ____________

Employer Address ____________ Employer Phone ____________

EMERGENCY CONTACT

Name ____________ Relationship ____________

Home Phone ____________ Cell ____________ Work ____________

Whom may we thank for referring you to us? ____________

PRIMARY INSURANCE

(Individual responsible for this account)

First Name ____________ Last Name ____________ Middle Initial ____

Relationship to patient ____________ Birth Date ____/____/____ Social Security # ____-____-____

Address ____________ City, State, Zip ____________

Employer ____________ Occupation ____________

Employer Address ____________

Insurance Company ____________

Subscriber ID # ____________ Group # ____________

ADDITIONAL INSURANCE

First Name ____________ Last Name ____________ Middle Initial ____

Relationship to patient ____________ Birth Date ____/____/____ Social Security # ____-____-____

Address ____________ City, State, Zip ____________

Employer ____________ Occupation ____________

Employer Address ____________

Insurance Company ____________

Subscriber ID # ____________ Group # ____________

ASSIGNMENT AND RELEASE

- I authorize my insurance to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all my insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.
- I authorize the dentist to perform any necessary treatments.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- **I understand that payment is due in full at time of treatment unless prior arrangements have been approved.**

Signature ____________ Birth Date ____/____/____

DENTAL HISTORY

Former Dentist ____________ Address ____________

Phone ____________ Date of last dental visit ___/___/___ Date of last x-rays ___/___/___

What would you like us to do today? ____________ Are you in dental discomfort today? ☐Y☐N

Check yes or no if you have ever had problems with any of the following:

☐Y☐N Bad Breath
☐Y☐N Bleeding Gums
☐Y☐N Clicking or popping jaw
☐Y☐N Food collection between teeth
☐Y☐N Grinding or clenching teeth
☐Y☐N Loose teeth or broken fillings
☐Y☐N Periodontal treatment
☐Y☐N Sensitivity to cold
☐Y☐N Sensitivity to hot
☐Y☐N Sensitivity to sweets
☐Y☐N Sensitivity when biting
☐Y☐N Sores or growths in mouth

How often do you brush? ____________ Floss? ____________

Have you ever experienced an adverse reaction during, or in conjunction with, a medical or dental procedure? ☐Y☐N

Other information about your dental heath or previous treatments: ____________

MEDICAL HISTORY

Physician's Name ____________ Phone ____________

Date of last visit ___/___/___ Reason you are under his/her care: ____________

Have you had any serious illnesses or operations? ☐Y☐N If yes, describe: ____________

Have you ever had a blood transfusion? ☐Y☐N If yes, give approximate dates: ____________

Have you ever taken Fen-Phen/Redux? ☐Y☐N Have you ever been advised to take antibiotics prior to dental treatment? ☐Y☐N

Women: Are you pregnant? ☐Y☐N Nursing? ☐Y☐N Taking birth control pills? ☐Y☐N

Check yes or no if you have ever had problems with any of the following:

☐Y☐N AIDS/HIV positive
☐Y☐N Anaphylaxis
☐Y☐N Anemia
☐Y☐N Arthritis, rheumatism
☐Y☐N Artificial heart valve(s)
☐Y☐N Artificial joints (hips, knees) Date: ____________
☐Y☐N Asthma
☐Y☐N Back problems
☐Y☐N Blood disease
☐Y☐N Cancer Details: ____________
☐Y☐N Chemical dependency
☐Y☐N Chemotherapy Date: ____________
☐Y☐N Circulatory problems
☐Y☐N Cortisone treatments
☐Y☐N Cough, persistent
☐Y☐N Coughing up blood
☐Y☐N Diabetes
☐Y☐N Epilepsy
☐Y☐N Fainting
☐Y☐N Food allergies
☐Y☐N Glaucoma
☐Y☐N Headaches
☐Y☐N Heart murmur
☐Y☐N Heart problems Details: ____________
☐Y☐N Hemophilia/Abnormal bleeding
☐Y☐N Herpes
☐Y☐N Hepatitis
☐Y☐N High Blood Pressure
☐Y☐N Jaw pain
☐Y☐N Kidney disease or malfunction
☐Y☐N Liver disease
☐Y☐N Latex allergy
☐Y☐N Mitral valve prolapse
☐Y☐N Nervous problems
☐Y☐N Osteoporosis
☐Y☐N Pacemaker/heart surgery
☐Y☐N Psychiatric care
☐Y☐N Rapid weight gain or loss
☐Y☐N Radiation treatment Date: ____________
☐Y☐N Respiratory disease
☐Y☐N Rheumatic/scarlet fever
☐Y☐N Shingles
☐Y☐N Shortness of breath
☐Y☐N Surgical implant(s)
☐Y☐N Stroke
☐Y☐N Swelling of feet or ankles
☐Y☐N Thyroid disease or malfunction
☐Y☐N Tobacco habit
☐Y☐N Ulcer/colitis
☐Y☐N Venereal disease

MEDICATIONS

List medications and dosages you are currently taking:

____
____
____
____
____

Pharmacy: ____________

Pharmacy Phone: ____________

ALLERGIES

☐ Aspirin
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other (please list)
____
____
____

Have you ever taken bisphosphonate drugs such as *Fosamax, Actonel, Zometa, Aredia, Didronel, Boniva, Bonefos* or *Skelid* used to treat osteoporosis or bone cancer? ☐Y☐N

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ADA | American Dental Association
ISDA | Idaho State Dental Association
WTVDS | Western Treasure Valley Dental Society
CareCredit Available

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

First Name ______________________ Last Name ______________________ Middle Initial ______

Street Address ____

City, State, Zip ______________________________ Phone ______________

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health care operations involving our office.

We have comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health Information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from other health professionals.

Similarly, the uses and disclosures of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; or submission of your health information to auditors hued by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change, You can get an updated copy here at our office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment of our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practice, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

IN HAVING READ THIS CONSENT AND, UNDERSTOOD IT, I CONSENT TO THIS USE AND DISCLOSURES OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

ASSIGNMENT AND RELEASE

Patient Signature ______________________________ Date ____/____/____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ______________________ Print Name ______________________

Source of Authority ____