

PERSONAL INFORMATION
DOWNTOWN DENTAL

Last name _____

First name _____

Middle initial _____

Preferred name to be called _____

Gender M F Married Single

Birth date _____/_____/_____

Social security number _____ --- _____ --- _____

Driver's license number _____

Address _____

Email address _____@_____

Can we email appointment reminders and billing statements to you? Yes No

Best phone number to talk to you _____

Best time to call you _____

Home phone _____

Work phone _____

Which method do you prefer to communicate? Phone Email Postal Service Text

Comments:

Guarantor of the account (Person responsible for payment)

Name _____

Social security number _____

Address _____

Phone number _____

EMPLOYER INFORMATION
DOWNTOWN DENTAL

Patient name:

Employer name:

Employer address:

Employer phone:

INSURANCE INFORMATION
DOWNTOWN DENTAL

Primary insurance:

Carrier: _____

Subscriber: _____

Subscriber ID: _____

Group #: _____

Subscriber's birth date _____ / _____ / _____

Release of information:

I authorize release of any information required by my insurance carrier

Signature _____

Release of payment (Assignments of benefits):

I authorize my insurance benefits to be paid directly to Downtown Dental*

Signature _____

*Please note: If not signed, you will be expected to pay for all dental services the day they are rendered. Insurance will then reimburse you after we file your claim.

Relationship to subscriber (Circle one)

- Self
- Spouse
- Child
- Other

PLEASE INCLUDE A FRONT AND BACK COPY OF YOUR CURRENT INSURANCE CARD

HIPAA FORM DOWNTOWN DENTAL

In accordance with HIP AA, we are legally obligated to have your written permission before we can disclose any health care information concerning you or your children to any other party.

CONSENT FOR USE AND DISCLOSURE OF HEALTHCARE INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT- 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 our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and 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 our privacy notice carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our "Notice of Privacy Practices" sheet. 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 us.

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 our office personnel. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

ACCEPTANCE OF CONSENT:

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, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCACTION OF CONSENT:

I revoke my Consent for your use and disclosure of my protected health Information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any action you take in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: _____

Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
DOWNTOWN DENTAL

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's
Notice of Privacy Practices on behalf of myself and my minor children, as listed:

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): _____

HEALTH HISTORY DOWNTOWN DENTAL

Patient Name: _____

Circle any of the following which you have had in the past or presently have:

Heart failure	Rash
Heart disease	Hives
Angina pectoris	Swelling
High blood pressure	Glaucoma
Heart murmur	Diabetes
Rheumatic fever – Strep. A infection	
*Congenital heart lesions	Arthritis
*Prosthetic cardiac valve	Glaucoma
*Cardiac transplantation	Jaw pain
*Previous endocarditis	Artificial joints
Scarlet fever	Cortisone medicine
Heart surgery	Rheumatism
High cholesterol	
Heart pacemaker	Ulcers
Emphysema	IBS – Irritable bowel syndrome
Cough	
Tuberculosis (TB)	Thyroid disease
Asthma	
Hay fever	Stroke
Sinus trouble	Anemia
	Sickle cell disease
Kidney disease	Bruise easily
	Blood transfusion
Cancer	Hemophilia
Radiation therapy	
Chemotherapy	HIV positive test
	AIDS
Liver disease	Venereal disease
Hepatitis A (infectious)	Genital herpes
Hepatitis B (serum)	Cold sores
Hepatitis C	
	Epilepsy
Drug addiction	Seizures
Psychiatric treatment	Fainting spells
Anxiety	
Joint replacements	Bisphosphonate therapy
Latex allergy	Osetopenic / Osteoporosis
Allergy to anesthetic	

Please list any condition not mentioned that you have: (Please list all) (If none, please write “none”)

Please name your physician: _____

Where does he/she practice: _____

What is their phone number: _____

Are you currently taking any prescribed medications? (Please list all) (If none, please write "none")

Are you allergic to any medication? (Please list all) (If none, please write "none")

Yes No Are you subject to prolonged bleeding?

Yes No Do you use tobacco? (Please list)

Yes No Are you pregnant?

Please list any other medical conditions not mentioned on this form that Dr. Kowalczyk should know about:

FINANCIAL POLICY
CANCELLATION POLICY
DOWNTOWN DENTAL

Dear Patient:

Welcome! Thank you for choosing us as your healthcare provider. Our main concern is that you receive optimal dental care. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor. If you should have any questions regarding our payment policy, please do not hesitate to contact our office staff.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, Discover, American Express, ATM cards and debit cards. For some cases we do offer financing through Care Credit. We will be happy to help you process your application and your insurance claim for your reimbursement as long as you bring the required information to each visit.

Our financial policy is as follows:

1. Payment for services is due in full at the time of treatment including any co-payments that are estimated.
2. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not your insurance company.
3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
5. If the insurance company does not pay after 60 days, we require you to pay the balance due with cash, check, or credit card.
6. Returned checks will be subject to additional fees. \$20 fee is the state of Idaho's maximum fee. This is what we will charge.
7. All balances over 90 days will be reviewed and possibly turned over to an agency for payment or will be sent to our Legal Counsel. You will be responsible for any additional charges incurred. A finance charge of 18% will be added to your outstanding balance if left unpaid over 90 days. This charge will be added for each 30 days past 90 days if left unpaid.
8. We reserve the right to charge a fee for broken appointments when less than 48 hours notice is received. First fee is \$20. Second fee is \$40. Third fee is \$60, and is the maximum fee.

We understand that temporary financial issues may affect timely payment of your account. We encourage you to communicate any such problems so that we may assist you in the management of your account.

By signing below, you agree to this Financial Policy stated above.

Patient Signature: _____ Date: _____

GENERAL CONSENT FORM DOWNTOWN DENTAL

PLEASE INITIAL IN THE BOX NEXT TO EACH SECTION.

1. DIAGNOSIS

I understand that during any appointment, through standard procedures conducted during an office visit, I may: obtain recommendations, advice, referrals, receive instructions regarding any home-care regimen, be asked for information as it relates to my status or condition, undergo clinical observations, diagnostic testing, obtain a personal treatment plan including possible treatment options, be provided the opportunity to access treatment costs, and make financial arrangements for necessary services.

2. RADIOGRAPHS (X-RAYS)

I understand that Dr. Ryan Kowalczyk, administering hygienists, and any assistants, may advise, request, and administer radiograph x-rays in order to provide more thorough and accurate diagnostic examinations. Most treatments are not feasible without radiographs.

3. DRUGS & MEDICATIONS (ANESTHETIC)

I understand that anesthetics, antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (sever allergic reaction). It is also likely that you may have partial or complete, temporary or permanent numbness in your mouth as a result of anesthetic injections. This is possible but unlikely.

4. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination; the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

5. REMOVAL OF TEETH (EXTRACTIONS)

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.), and I authorize the Dentist to remove the necessary teeth for reasons provided in content explanation. I understand removing teeth does not always remove all the infection if present, and it may be necessary to render further treatment. I understand there are risks involved with having teeth removed, some of which are: pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months), or a fractured jaw. I understand I may require further treatment from a specialist or even hospitalization if complications arise during or following treatment; the cost of which is my responsibility.

6. CROWNS AND BRIDGES (ANESTHETIC)

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including: shape, fit, size, and color) will be before cementation.

7. DENTURES (COMPLETE OR PARTIAL)

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including: looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new dentures (including: shape, fit, size, placement, and color) will be during the "teeth-in-wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fees. I understand the wearing of dentures is difficult. Sore spots, altered speech and difficulty in eating are some common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delay of more than 30 (thirty) days, there will be additional charges in connection with the services provided.

8. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment. It is also possible that files can break within the tooth root during treatment. This is not desired, but can occur. I understand that occasionally surgical procedures may be necessary following root canal treatment (apicoectomy) if the traditional root canal therapy is unsuccessful. I realize that any additional treatment is my cost.

9. PERIODONTAL LOSS (TISSUE & BONE)

I realize that when plaque and calculus/tartar are not removed, it begins to destroy the gums (red, swollen, bleeding) and underlying bone, accompanied by infection, collectively destroying the tissue responsible for maintaining tooth stability, making periodontal disease the number one reason for tooth loss. I realize that it is my responsibility to obtain the necessary appointments, reflect healthy priorities, and maintain good oral hygiene by implementing quality home-care routines and undergo maintenance periodontal cleanings, (above and below the gum line) essential to my health. In performing continuous efforts, alongside the doctors (Dentist/Periodontist), I will have greater success in keeping periodontal disease under control. I realize that receiving care from an outside facility will accompany its own fees. I understand that there is no guarantee that performing the recommended practices, will prolong the retaining of my teeth; regardless of the routine maintenance, I may still experience the loss of teeth.

10. FILLINGS

I understand that care must be exercised in chewing on fillings, especially during the first 24 (twenty-four) hours, to avoid breakage. I understand that a more expensive filling than initially diagnosed may be required due to additional decay. I understand that sensitivity can result after a newly placed filling.

I understand that dentistry is not an exact science and therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian if patient is a minor: _____