Patient Registration (Please complete all blanks)

Date_____

Patient Name_____Social Security/ID# _____
Address_____City_____State_____Zip_____
E-mail_____
Telephone: Home_____Cell_____Work_____
Birthdate: M_____D_____Y_____ Age_____ Male: O Female: O
Occupation_____Business Name_____

Parent/Spouse Name_____
Social Security/ID# _____ Birthdate: M_____D_____Y_____
Telephone: Home_____Cell_____Work_____
Occupation_____Business Name_____

Person responsible for account_____ Relation_____
Emergency Contact (other than parent/spouse)_____Phone_____
Previous Dentist_____

Referred By: **O** - patient referral **O** -1800dentist **O** - phonebook **O** - walkin
O – website **O** – google **O** – other_____

Authorization for Treatment

I_____hereby grant authority to Dr. Bradford B. Fisher D.D.S., located at 207 7th Avenue S Nampa, Idaho 83651, and/or to the dentist(s) in charge of my care, permission to administer any treatment; anesthetics; or to perform such operations as may be deemed necessary in the diagnosis and treatment of my case. I further acknowledge my right to be informed of the risks and possible consequences of the treatment proposed and do authorize the above named doctor(s) to process.

Signature _____**Date**_____
(Patient or nearest relative/guardian if minor or disabled)

Dental Insurance – Policy Holders Information

Name _____ SS/ID#_____ Group#_____

Insurance Company_____Relationship Self Spouse Child Other

Secondary Insurance (if any)

Name _____ SS/ID#_____ Group#_____

Insurance Company_____Relationship Self Spouse Child Other

Medical History

This medical information is important to help us help you. Please take a few minutes to complete the information below. Check **ANY** of the following conditions that you have experienced in the past or are currently experiencing:

O Heart Failure	O Emphysema	O Cortisone Medication
O Heart Disease	O Cough	O Glaucoma
O Angina	O Tuberculosis	O Jaw Pain
O High Blood Pressure	O Asthma	O HIV/AIDS
O Low Blood Pressure	O Lung Disease	O Hepatitis A___B___C___
O Heart Murmur	O Hay Fever	O Liver Disease
O Rheumatic Fever	O Sinus Problems	O Kidney Disease
O Congenital Heart Valve	O Allergies	O Blood Transfusion
O Scarlet Fever	O Diabetes	O Hemophilia
O Artificial Heart Valve	O Thyroid Disease	O Veneral Disease
O Heart Surgery (Year_____)	O X-ray Colbalt Therapy	O Cold Sores
O Cardiac Pacemaker	O Chemotherapy	O Acid Reflex/Stomach Conditions
O Artificial Joint	O Osteoporosis/Bone Density	O Eplilepsy/Seizures
O Anemia	O Use of Bisphosphonates	O Fainting /Dizziness
O Stroke	ie-Aredia, Zometa(IV)	O Nervousness
O Alcoholism	Boniva, Fosamax (pills)	O Psychiatric Care
O Use Tobacco	O Arthritis	O Bruise Easily
O Drug Addiction	O Rheumatism	O Ulcers

Medical Doctors_____

Are you having pain or discomfort?	O Yes	O No
Have you been hospitalized during the past two (2) years?	O Yes	O No
Are you currently taking or have taken any medication in the past (2) years?	O Yes	O No

Please list **ALL** medications _____

Are you **allergic** to: Medication (Penicillin, Aspirin, Codeine, Novocaine) Latex, Jewelry	O Yes	O No

Other_____

Have you ever had excessive bleeding which required special care?	O Yes	O No
Do you have shortness of breath walking up stairs or sleeping?	O Yes	O No
Do you tire easily?	O Yes	O No
Do you ankles swell during the day?	O Yes	O No
Is it necessary to use more than two pillows to sleep?	O Yes	O No
Have you lost or gained more than ten pounds during the past year?	O Yes	O No
Are you on a special diet?	O Yes	O No
Has your medical doctor diagnosed cancer or a tumor?	O Yes	O No

Women: Are you pregnant? O Yes O No **How far along?** _____

Are there any other problems, disease, or conditions that we should know about?	O Yes	O No

_____

To the best of my knowledge, all the preceding answers are true and correct. If my health should change, or if my medications should change, I will inform the dentist at my next appointment without fail.

Signature _____ **Date**_____

Thank you for your help in completing this form.

Fisher Dentistry Financial Policy

Thank you for choosing Fisher Dentistry for your dental needs. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience we accept cash, check, Mastercard, Visa, Discover, American Express, and Care Credit.

For patients needing an extended payment plan we offer **Care Credit Card** (healthcare credit cards). A simple application is submitted and within minutes, if approved, you will have a line of credit for dental care with low monthly payments up to twelve months to pay interest free in some cases.

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. If cancellations within the 24 hour period occur, or, an appointment is failed without notice, a $30 fee may be charged.

Insurance Explanation

Your insurance policy is a contract between you and your insurance company, the doctor is not involved. As a courtesy, we bill your insurance plan directly. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list); however, we are not preferred providers with all of the ones we accept. It is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

Refunds

If your estimated patient portion results in a credit to your account you may leave the credit on file for future dental visits or we will gladly refund any requested credits. Please allow up to 14 business days to process your request.

Signature: _____ Date:_____

Parent (If Minor): _____ Date:_____

Fisher Dentistry

Bradford B Fisher, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, you can request a copy at any time. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand by signing this consent I authorize you to use and disclose my protected health to carry out,

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our practice.

I, _____, have reviewed a copy of this Office's Notice of Privacy Practices.

Name (Printed): _____ Date: _____

Signature: _____