Iowa River Dentistry
Dr. Bryn E. Johnson, DDS
(641) 648-4237 IowaRiverDentistry.com

PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ /_____ /_____ SS#: _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOW DID YOU HEAR ABOUT US? _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL: _____

PREFERRED PHARMACY: _____ CITY: _____

EMPLOYER: _____ CITY: _____ PHONE: _____

WHAT IS YOUR PREFERRED METHOD OF NOTIFICATION? ☐ HOME ☐ CELL ☐ WORK ☐ EMAIL

☐ I AUTHORIZE THIS OFFICE TO SEND APPOINTMENT REMINDER INFORMATION VIA TEXT TO MY CELL PHONE.

☐ I AUTHORIZE THIS OFFICE TO SEND PRACTICE AND HEALTHCARE INFORMATION TO MY EMAIL ADDRESS.

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID#: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

OTHER INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

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In our office, we do not want finances to prevent patients from receiving the care they need and desire. A part of your comfort and satisfaction with our office is your ability to choose the payment options best suited to your personal situation. As a courtesy to you, we will submit insurance claims on your behalf to help you receive your maximum allowable benefits. In return we ask that the patient portion be paid at the time of service.

Due to constantly changing insurance regulations, benefits and deductibles, we are only able to *approximate* your insurance balance.

For your convenience we offer the following payment options.

1) Cash/Check payment- 5% discount will be given for this option
2) Visa/MasterCard/Discover/American Express
3) Care Credit- An outside finance company offering interest free options and low monthly payments based on the dollar amount requested. Apply online at www.carecredit.com or visit our website for a link to Care Credit- www.iowaimplantdentistry.com.

REGARDING APPOINTMENTS, PAYMENTS, AND INSURANCE

- Changes to appointments require 24 hours notice to avoid a missed appointment fee.
- We are happy to submit a claim to your insurance company on your behalf.
- Patient balances and co-payments are due the day of your visit.
- Balances not paid by insurance within 90 days are the account holder's responsibility.
- We offer a discount for cash/check payments in full on the day of your visit.
- If you receive a payment from your insurance company please contact our office as it may be payment on a claim that is due to Iowa River Dentistry for services rendered.
- ***We value you as our patient and understand finances influence treatment decisions. Please don't hesitate to contact us if you would like to discuss your treatment and financial options in person.***

Signature: _____ Date: _____

922 Washington Avenue, Iowa Falls, IA 50126
(641) 648-4237 fax (641) 648-4239

POS Reorder # 1817963

MEDICAL HEALTH HISTORY

Patient Name: _____ Birth Date: _____

Who is your primary physician? _____

How long has it been since your last visit with your physician? _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes: _____

Are you taking any medications? ☐ Yes ☐ No If yes, please list: _____

_____

Do you take an antibiotic pre-medication before dental treatment? ☐ Yes ☐ No If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes: _____

Are you on a special diet? ☐ Yes ☐ No If yes: _____

Do you use tobacco? ☐ Yes ☐ No If yes, what type/how often: _____

Do you use alcohol? ☐ Yes ☐ No If yes, how much: _____

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No If yes: _____

Are you nursing? ☐ Yes ☐ No If yes: _____

Are you taking oral contraceptives? ☐ Yes ☐ No If yes: _____

Do you have any behavioral disorders or mental health diagnoses? ☐ Yes ☐ No If yes: _____

Are you allergic to any of the following?

Aspirin	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No	Latex	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Metal	☐ Yes ☐ No	Local Anesthetics	☐ Yes ☐ No

Other ☐ Yes ☐ No **If yes, please list:** _____

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

	Yes	No		Yes	No		Yes	No
Chest pain	☐	☐	Blood transfusions	☐	☐	Radiation treatments	☐	☐
Shortness breath	☐	☐	Blood thinner/anticoagulant	☐	☐	Kidney/bladder problems	☐	☐
Heart attack	☐	☐	Diabetes	☐	☐	Stomach/intestinal disease	☐	☐
High blood pressure	☐	☐	Hypoglycemia	☐	☐	Ulcers	☐	☐
Low blood pressure	☐	☐	Thyroid problems	☐	☐	Weight gain/loss	☐	☐
Heart valve problems	☐	☐	Arthritis	☐	☐	Hepatitis, jaundice, liver trouble	☐	☐
Taking heart medications	☐	☐	Osteoporosis	☐	☐	Herpes or other STD	☐	☐
Pacemaker	☐	☐	Back/neck pain	☐	☐	HIV positive/AIDS	☐	☐
Stroke	☐	☐	Joint replacement	☐	☐	Alcohol or drug addiction	☐	☐
Dry mouth	☐	☐	Autism	☐	☐	Glaucoma	☐	☐
Sjogren's disease	☐	☐	Attention deficit disorders	☐	☐	Tuberculosis, respiratory disease	☐	☐
Seizure disorders	☐	☐	Frequent/severe headaches	☐	☐	Emphysema	☐	☐
Fainting spells	☐	☐	Sleep apnea	☐	☐	Lung disease	☐	☐
Bruise easily	☐	☐	CPAP	☐	☐	Asthma	☐	☐
Abnormal bleeding	☐	☐	Snoring	☐	☐	Seasonal allergies	☐	☐
Blood disease (anemia)	☐	☐	Cancer/tumor	☐	☐	Sinus problems	☐	☐
Leukemia	☐	☐	Chemotherapy	☐	☐	Tonsillitis	☐	☐

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes: _____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ **Date:** _____

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Iowa River Dentistry. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur in my treatment, payment for services, or in the performance of the office health care operations. The Notice of Privacy Practices also describe my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Iowa River Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY ☐ YES ☐ NO
SPOUSE/PARTNER ONLY ☐ YES ☐ NO
OTHER (PLEASE SPECIFY) _____ ☐ YES ☐ NO

_____ _____
Name of Patient **Signature of Patient** or Personal Representative

_____ _____
Date Description of Personal Representative

Record of Acknowledgment not obtained for the following reason:

☐ Needed more time to review Notice of Privacy Practices.
☐ Wanted to consult with another person before signing.
☐ Unable to sign.
☐ Reason not given
☐ Other (explain)

Release of Insurance Benefits

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with insurance claims.

I hereby authorize and direct payment of the dental benefits otherwise payable to me directly to Iowa River Dentistry. If I receive a check from my insurance company I will contact Iowa River Dentistry to see if it should be a payment for services rendered by their office.

_____ _____
Name of Subscriber Signature of Subscriber or Personal Representative

_____ _____
Date Description of Personal Representative

Iowa River Dentistry complies with the applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Atención: Si hablas a español, tienes a tus disposición gratis idioma ayuda servicios. Llame al (641) 648-4237.

注意： 如果你会说西班牙语，你有在你处置免费语言援助服务。打电话给办公室 （电话 (641) 648-4237.

POS Reorder # 1817965