Boise Toothtown Dentistry for Kids
13014 W. Persimmon Lane
Boise, Idaho 83713
(208) 377-2072
www.boisetoothtown.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date (mm/dd/yyyy):

Patient Information

First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy):	Home Phone:	School:	Grade:

Home Address:	Social Security #:	City:	State:	ZIP Code:

Place of Birth:	Medical Alert:

Names & ages of brothers and sisters:

Hobbies, sports, pets, and other interests:

Please tell us where you heard about us:

Was our website a factor in your decision to visit our practice? ○ Yes ○ No

Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Home Phone:	Cell Phone:

Person Responsible for Account

Title:	First Name:	Last Name:

Financial understanding is essential for all parties concerned. Thank you!

Cash Charge Card Insurance ☐ Medicaid ☐ Other

I would be interested in learning about third party financial options.

Parent or Guardian Information

☐ Mother ☐ Stepmother ☐ Guardian

Title:	First Name:	Last Name:	Email Address:	
Employer:	Home Phone:	Work Phone:	Cell Phone:	Social Security #:
Date of Birth (mm/dd/yyyy):	Home Address:		City:	State: ZIP Code:

Parent or Guardian Information

☐ Father ☐ Stepfather ☐ Guardian

Title:	First Name:	Last Name:	Email Address:	
Employer:	Home Phone:	Work Phone:	Cell Phone:	Social Security #:
Date of Birth (mm/dd/yyyy):	Home Address:		City:	State: ZIP Code:

Dental History

How often does your child brush?	How often does your child floss?
Date of last dental visit (mm/yyyy):	Previous Dentist:

Previous Dentist Address:

Has your child had difficulty with previous dental visits? ○ Yes ○ No

Has your child had a toothache recently? ○ Yes ○ No

Has your child ever fallen and chipped or damaged any of his/her teeth? ○ Yes ○ No

At what age did your child stop bottle/breast feeding?

Does your child... (check all that apply)

☐ Suck Thumb/Finger ☐ Bite/Chew Nails ☐ Grind Teeth ☐ Snore
☐ Suck/Bite Lip ☐ Chew Hard Objects ☐ Clench Jaws ☐ Sleep Apnea

Medical History

Is your child currently under medical treatment? If yes, what for?

Does your child require antibiotic pre-medication for your dental work? If yes, what for?

Does your family have a history of complications from general anesthesia? ○ Yes ○ No
If so, what type of complications?

Physician's Name:	Phone:	Last Visit (mm/yyyy):

Address:	City:	State:	ZIP Code:

Do we have permission to contact your child's doctor regarding your child's care? ○ Yes ○ No

Is your child currently taking any medications and/or birth control? ○ Yes ○ No If yes, please list:

Has your child ever had:

☐ Heart Murmur/Trouble	☐ Hepatitis A, B, or C	☐ Cancer/Chemotherapy	☐ Congenital Heart Defect
☐ Kidney Problems	☐ Liver Problems	☐ Tuberculosis	☐ Convulsions/Epilepsy
☐ Asthma	☐ Rheumatic Fever	☐ Hemophilia	☐ Cleft Lip/Palate
☐ Diabetes	☐ Stomach Problems	☐ Abnormal Bleeding	☐ Pneumonia
☐ Head Trauma Fainting	☐ Sinus Trouble	☐ Glandular Problems	☐ Cold Sores
☐ Nervousness Scarlet	☐ Anemia	☐ Motion Sickness	☐ Fever Blisters
☐ Fever	☐ Hay Fever	☐ Bronchitis	☐ Lung/Respiratory Problems
☐	☐ High Blood Pressure	☐ Blood Disease	☐ Ear infections

Has your child ever had an adverse reaction or allergies to any medication or substance? *Check all that apply.*

☐ Aspirin ☐ Iodine ☐ Penicillin/Antibiotics ☐ Other:

Please list any previous hospitalizations/surgeries/serious illnesses, other serious medical conditions, impending operations, or other medical/dental information with correlating dates that may possibly affect your child's dental treament:

Insurance Information

Primary Insurance

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Ins. Holder Social Security #:	Relationship to Patient:
Employer:		Date Employed (mm/yyyy):	Group #:

Insurance Company Name:	Insurance Company Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Ins. Holder Social Security #:	Relationship to Patient:
Employer:		Date Employed (mm/yyyy):	Group #:

Insurance Company Name:	Insurance Company Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Boise Toothtown to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Boise Toothtown. I permit a copy of this authorization to be used in place of the original. I give Boise Toothtown, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

Consent for Treatment

Patient Name:

• I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.
• Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.
• I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
•I have read, understood, and agree to the above treatment policy.

Signature (type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Boise Toothtown to use and/or disclose my protected health information to carry out the following:

- **Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.**
- **Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.**
- **The day to day healthcare operations of your dental practice.**

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

If signing on behalf of someone, explain your relationship to the patient:

Boise Toothtown Dentistry for Kids

Dr. Rod Emory D.D.S

I have received a copy of this office's
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
(HIPAA)
*You may refuse to sign this acknowledgement**

Patient name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our

NPP

(Notice of Privacy Practices)
Acknowledgement could not be obtained because:

Patient refused to sign.

Communication/language barrier prevented us from communicating Notice of Privacy Practices.

Other (please specific)

_____