Little Mountain
Dental

Date: _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Birth Date: _____ Age: _____ Male Female
SS# _____ Marital Status: S M W D Sep
Street/Mailing Address: _____City/State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address:_____
Preferred method of contact: Home phone, Cell Phone, Work Phone, E-mail, Text Message
Employer: _____ Position: _____

How did you hear about our office? Friend/ Relative: (name) _____ Phone Book _____
Internet _____ Insurance _____ Office Location _____ Other: _____

Responsible Party Information:

□Check if same as above
First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Birth Date: _____ Male Female
Street Address: _____ Mailing Address: _____
City/State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Relationship to Patient: _____ SS#:_____ Email Address: _____
Employer: _____ Work Phone: _____

Emergency Contact Information:

Spouse's/ Parent's Name: _____ Birth Date: _____ Phone: _____
Address: _____ City: _____ State/Zip: _____
Spouse's/ Parent's Employer: _____ Work Phone: _____
Nearest relative not living with you: _____ Relationship: _____ Phone: _____

Insurance Information:

1. Insurance Company (Primary)
Insured/ Policy Holder: _____
Birth Date: _____ SS#: _____
Employer Name: _____
Phone: _____
Insurance Company: _____
Phone: _____ Group #: _____
Member/Policy ID #: _____
Relationship to patient: _____

2. Insurance Company (Secondary)
Insured/ Policy Holder: _____
Birth Date: _____ SS#: _____
Employer Name: _____
Phone: _____
Insurance Company: _____
Phone: _____ Group #: _____
Member/Policy ID #: _____
Relationship to patient: _____

Little Mountain Dental Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Circle all that apply:

Is your general health good? Y N

Are you under a physician's care now? Y N If yes, please explain: _____
_____

Are you taking any medications? Y N If yes, please explain: _____
_____

Have you ever had trouble with bleeding after surgery? Y N If yes, please explain: _____
_____

Have you ever had an unusual reaction to local anesthetics? Y N If yes, please explain: _____
_____

Have you ever taken Fen-Phen or Redux? Y N If yes, please explain: _____
_____

Is there any other information about your health which should be known? Y N If yes, please explain:
_____
_____

Do you use Tobacco? Y N

Do you have, or have you had any of the following: Circle all that apply

AIDS/HIV Positive	Diabetes		
Angina	Drug Addiction	Herpes	Shingles
Arthritis/Gout	Epilepsy or Seizures	High Blood Pressure	Sinus Trouble
Artificial Heart Valve	Excessive Bleeding	Kidney Problems	Stroke
Artificial Joint	Fainting Spells/Dizziness	Liver Disease	Tonsillitis
Asthma	Frequent Headaches	Low Blood Pressure	Tuberculosis
Cancer	Heart Attack/Failure	Mitral Valve Prolapse	Tumors or Growths
Chemotherapy	Heart Murmur	Pain in Jaw Joints	
Chest Pains	Heart Pace Maker	Psychiatric care	
Cold Sores/Fever Blisters	Heart Trouble/Disease	Radiation Treatments	
Congenital Heart Disorder	Hepatitis A	Rheumatic Fever	
Convulsions	Hepatitis B or C	Scarlet Fever	

Women are you:

Pregnant, trying to get pregnant, or nursing

Taking birth control

Are you allergic to any of the following:

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other: _____

LATEX IS USED IN OUR OFFICE, PLEASE INFORM ASSISTANTS OF ALLERGY.

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 _____ Date _____

Office Financial Policy &
Patient Consent Form

Our mission is to deliver the finest, most cost effective dental treatment available today. In an effort to do this and as a service to you we have designed the following office policy.

Payment for today's services and future visits are due at the time of treatment. Dental Insurance is a contract between a patient/guardian and the insurance company and in no way absolves the patient/guardian of full responsibility for the charges incurred. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated and the ultimate responsibility for payment belongs to the patient. **All co-pays and co-insurance payments are due in full before treatment is given.** We are pleased to help process insurance forms, help maximize your insurance benefits and are glad to help answer any questions you may have about your treatment or treatment estimates. We expect our patients to know their insurance policy and provide us with the proper billing information as well as inform us of any services they do not wish to receive. Any portion unpaid by the insurance company after 60 days from the start of treatment is the patient's responsibility. **If you do not have any dental insurance, payment in full is always required at the time of service.**

The time scheduled for your visit is set aside especially for you. We look forward to making your visit pleasant, comfortable, and productive. In the unlikely event you are unable to make your appointment; we ask that you give us 24 hours notice so that we may give this time to other patients needing treatment. There will be a charge of $35.00 for appointment(s) missed or broken without 24 hours prior notice. A monthly finance charge of 1.5% (18% annually) will be added to all account balances not paid within 60 days of services. All returned checks are subject to a $20.00 fee. If your account is delinquent it may be turned over to a collection agency and reported to the credit bureaus. A 35% collection agency fee will be added to the account at the time it is turned over and all court costs and reasonable attorney fees are the patient's responsibility.

I understand that I have certain rights to privacy regarding my protected health information. I understand that by signing the consent I authorize Little Mountain Dental to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers, and the day-to-day healthcare operations of your practice.

I authorize Dr. Aaron J. Stobbe and/or Dr. Michael Eggett or such associates/assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the health of any minor or other individual for which I have responsibility, including arrangement and/or any pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, surgical, or orthodontic treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I have read, understand and agree to the above policy.

_____ _____

Signature of Patient/Responsible Party Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.