mint Dental Care

New Patient Form

1415 N. Fillmore St. Suite 701 Twin Falls, ID 83301 208-735-1415

Patient Information

Name_____ I prefer to be called_____

Address_____ City_____ State_____ Zip Code_____

Cell Phone (____)_____-_____ Home Phone (____)_____-_____

Email _____ Date of Birth _____/_____/_____

SS Number_____-_____-_____ Drivers License #_____

Check Appropriate Box: Gender: Male ☐ Female ☐

Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Parent or Spouses Name:_____ Phone Number (___)_____-_____

Emergency Contact _____ Phone Number (____)_____-_____

Who may we thank for referring you?_____

Responsible Party

Name_____ Relationship to Patient _____

Address_____ City_____ State____ Zip Code_____

Cell Phone (____)_____-_____ Employer_____ Work Phone(____)_____-____

Is this person currently a patient in our office? Yes ☐ No ☐

Dental Insurance Information

Name of Insured_____ DOB_____ Relationship_____

Drivers License #_____ Employer_____ Work #(____)_____-_____

Address of Employer _____ City_____ State_____ Zip Code_____

Insurance Company_____ Group #_____ ID#_____

Company Address _____ Phone # (____)____-_____

Additional Dental Insurance

Name of Insured_____ DOB_____ Relationship_____

Drivers License #_____ Employer_____ Work #(____)_____-_____

Address of Employer _____ City_____ State_____ Zip Code_____

Insurance Company_____ Group #_____ ID#_____

Company Address _____ Phone # (____)____-_____

Authorization and Release: I verify that I have read and understood the information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

X_____ Date_____

Signature of Patient (or parent/guardian of minor)

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Health History

General Health History

Do you have any of the following conditions? (check all that apply)

ADD/ADHD	☐	Seasonal Allergies	☐
Anxiety	☐	Shortness of Breath	☐
Autism	☐	TMJ Pain	☐
Asthma	☐	Fibromyalgia/Chronic Body Pain	☐
Cancer	☐	Chronic Neck pain	☐
Chronic Sinus Congestion	☐	Obstructive Pulmonary Disease	☐
Depression	☐	Difficulty Swallowing	☐
Mental Health Problems	☐	Acid Reflux/Heartburn	☐
Thyroid Conditions	☐	Stomach Ulcers	☐
Liver Disease	☐	Irritable Bowel Syndrome	☐
Fever Blisters/Herpes	☐	Diabetes	☐
Aids/HIV Infection	☐	High Cholesterol	☐
Tuberculosis	☐	High Blood Pressure/Hypertension	☐
Other Contagious Disease	☐	Heart Rhythm Abnormalities	☐
Kidney/Bladder Trouble	☐	Cardiac Pacemaker	☐
Sexual Problems	☐	Heart Valve Replacement	☐
Dry Mouth/Eyes	☐	Heart Disease	☐
Gum (periodontal) Disease	☐	History of Heart Attack	☐
Fainting Spells/Seizures	☐	History of Stroke	☐
Epilepsy	☐	Blood Clotting Problems	☐
Joint Replacement	☐	Blood Disorders	☐
Trauma/Injury to Face	☐	Hepatitis	☐
Tinnitus (ringing in the ears)	☐	Other_____	☐

Please provide details of any of the selected conditions above:

_____

_____

_____

Are you currently being treated for any injury or illness? Yes ☐ No ☐

Provide details here:

_____

_____

_____

Do you have chronic headaches? Yes ☐ No ☐

If Yes, describe the headache and what relieves it: _____

_____

_____

Have you ever had an allergic reaction? Yes ☐ No ☐

Provide details here: _____

_____

_____

Are you allergic to any of the following? (check all that apply)

Latex	☐	Pain Medications	☐
Metal	☐	Plastic	☐
Acrylic	☐	Food	☐
Contrast Dye	☐	Antibiotics	☐

Please list all other allergies (including medications): _____

_____

Sleep Health History

Do you have any of the following conditions? (check all that apply)

Snoring	☐	Night Terrors	☐
Central Sleep Apnea	☐	Excessive Daytime Sleepiness	☐
Obstructive Sleep Apnea	☐	Narcolepsy	☐
Insomnia	☐	Periodic Limb Movement	☐
Restless Leg Syndrome	☐	Circadian Rhythm Disorder	☐
Sleep Walking	☐	Bed Wetting	☐

Have you ever had a sleep study done? Yes ☐ No ☐

Approximate date and location of most recent sleep study: _____

_____

Have you currently or previously used any of the following treatments for OSA?

Mandibular Advancement Device	Current ☐	Past ☐
Hyopglossal Nerve Stimulation (INSPIRE)	Current ☐	Past ☐
CPAP	Current ☐	Past ☐
Myofunctional Therapy	Current ☐	Past ☐
Airway Surgery	Yes ☐	No ☐
Tongue Tie Release (Frenectomy)	Yes ☐	No ☐

Do you have a primary care provider (including pediatrician)? Yes ☐ No ☐

Name & location of provider:_____

Do you have a sleep specialist or ENT? Yes ☐ No ☐

Name & location of provider:_____

Date of last physical exam:_____/_____/_____

Medications

Please list any medications you are taking (prescription, OTC, herbal supplements):

_____

_____

Are you required to pre-med w/antibiotics before dental treatment? Yes ☐ No ☐

Surgeries/Hospitalizations

Have you had surgery on/for any of the following? (check all that apply)

Nose ☐	Sleep Apnea ☐	Tonsils/Throat ☐
Tongue ☐	Weight Loss ☐	Adenoids Removed ☐
Palate/Lips ☐	Sinus ☐	Neck ☐
Back (spine) ☐	Jaw ☐	Lungs ☐
Brain ☐	TMJ ☐	Teeth ☐

Please list ALL previous surgeries or procedures within the past 12 months:

_____

_____

Are you planning on any upcoming surgeries or procedures? Yes ☐ No ☐

If yes, what surgery?_____When is it scheduled?_____

Have you been hospitalized within the past 5 years? Yes ☐ No ☐

Family & Social History

Does your family have a history of any of the following? (check all that apply)

High Blood Pressure	☐	Anxiety	☐
Diabetes	☐	Depression	☐
Obesity	☐	Heart Disease	☐
Snoring	☐	Stroke/Heart Attack	☐
Insomnia	☐	Cancer	☐
Sleep Apnea	☐	Restless Leg Syndrome	☐

Family History Details: _____

_____

Are you a current or former smoker?	Current ☐	Past ☐
Do you or have you used tobacco products?	Current ☐	Past ☐
Do you regularly consume caffeine or sugary drinks?	Yes ☐	No ☐
Are you pregnant or planning to become pregnant?	Yes ☐	No ☐
Do you have children?	Yes ☐	No ☐
Are you currently breastfeeding?	Yes ☐	No ☐

X_____ Date_____

Signature of Patient (or parent/guardian of minor)

mint
Dental Care

Dental History

General Information

Who was your previous dentist, where, and how long were you a patient there?

_____

When was your last teeth cleaning? _____

How often do you brush your teeth? _____

Do you have any immediate concerns you'd like us to address?

Bad Breath or Bad Taste in Mouth	Yes ☐	No ☐
More Attractive Smile	Yes ☐	No ☐
Crooked/Crowded Teeth	Yes ☐	No ☐
Discoloration	Yes ☐	No ☐
Missing Teeth	Yes ☐	No ☐
Tooth Pain	Yes ☐	No ☐

Other_____

Is there any specific part of your smile you'd like to improve?

_____

Has anything prevented you from addressing this concern in the past?

_____

Dental & Orthodontics

Are you planning on any upcoming dental work?	Yes ☐	No ☐
Are you currently undergoing any orthodontic treatment?	Yes ☐	No ☐
Have you had any orthodontic treatment in the past?	Yes ☐	No ☐

If yes, please check all that apply:

IPR (slimming teeth in ortho)	Current ☐	Past ☐
Wore headgear	Current ☐	Past ☐
Permanent teeth removed for ortho	Current ☐	Past ☐

Who's your orthodontist?_____

Office Relationship

What do you Value most in your Dental Visits?_____

Does dental treatment make you nervous?

Extremely ☐ Moderately ☐ Slightly ☐ No ☐

Personal History

Have you had any cavities within the past 2 years?	Yes ☐	No ☐
Do you have difficulty chewing or biting on hard foods?	Yes ☐	No ☐
Do you clench your teeth in the daytime?	Yes ☐	No ☐
Do you clench your teeth in your sleep?	Yes ☐	No ☐
Do you bite your nails, or chew on objects such as pens or shirt sleeves?	Yes ☐	No ☐
Do you experience dry mouth?	Yes ☐	No ☐
Do you have any missing teeth (removed or never developed)?		
Have you been told you have gum disease or gum recession?	Yes ☐	No ☐
Do your gums bleed or is it painful when brushing or flossing?	Yes ☐	No ☐
Are your teeth becoming more crowded, overlapped, crooked, or loose?	Yes ☐	No ☐

Are your teeth developing spaces?	Yes ☐	No ☐
Do you frequently get food caught between any teeth?	Yes ☐	No ☐
Do you wear dentures or partials?	Yes ☐	No ☐
Do you experience burning on your tongue or lips?	Yes ☐	No ☐
Do you have problems with your jaw joint? (TMJ, popping, clicking, deviating from side to side when opening/closing)?	Yes ☐	No ☐
Have you ever had any difficult extractions or prolonged bleeding following extractions?	Yes ☐	No ☐
Do you have swelling, lumps, or blisters in your mouth?	Yes ☐	No ☐
Do you bite your cheeks or lips?	Yes ☐	No ☐

X_____ Date_____

Signature of Patient (or parent/guardian of minor)

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Financial Policy

Financial Policy

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Full Payment IS DUE AT TIME OF SERVICE unless prior arrangements have been made. For your convenience we accept case, check, Visa or Master Card, Discover, American Express, or the pre-approved Care Credit.

We do require co-pay and/or deductible to be paid at the time of service along with your estimated portion of the procedure charges.

We will be happy to bill your insurance after you have provided us with your correct insurance information.

Your Insurance Policy is a Contract Between you and your Insurance Company and therefore you are responsible for payment in full.

No interest will be charged for the first 30 days. Our interest rates are 1.5% per month on any unpaid balance.

COLLECION FEES:
Occasionally it becomes necessary to use an outside collection service to receive payment.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy

X_____ Date_____

Signature of Patient (or parent/guardian of minor)

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Privacy Policy

Privacy Policy Consent

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization: or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider).
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPPA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and

filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

I acknowledge and agree☐ I acknowledge and refuse☐

X_____ Date_____

Signature of Patient (or parent/guardian of minor)