Dr. Tom Gudmestad, D.D.S.P.A.
Comprehensive Family Dentistry
522 E 4th Street
Weiser, Idaho 83672
(208) 549-2213

Patient Information

Patient Name:_____ Date_____
Last, First, MI. (Preferred Name)
Social Security #:_____Birth Date:_____ Age:_____

Phone (Home):_____ (Work):_____ Ext:_____ Best time to call: _____

Address: _____
Street City State Zip Code

Responsible Party_____Address_____

Social Security #:_____Birth Date_____Spouse_____

Employer (Name, Address, Phone)_____

Who do we contact in case of an emergency

Name_____Work Phone_____Home Phone_____

Closest relative not living with you?
Name_____Work Phone_____Home Phone_____

Health Information

Date of Last Dental Visit:_____ Reason for this visit: _____

Former Dentist_____Address_____

Medications you are currently taking_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided is true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice:_____

Insurance Information

Name of Insurance_____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Consent for Services

Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

* **Payment is due at the time of service.**
* **We do accept VISA/MASTERCARD/ & DISCOVER**
* **We offer extended payment plans with prior credit approval**

Medicaid Insurance

Patients who carry Medicaid Insurance are responsible for keeping current each month with their requirements to be on the program. During treatment if you or a family member becomes ineligible for the Medicaid Program, you will be responsible for any remaining balance. It is up to the responsible party, parent, or guardian to be aware of limitations on treatment that may have been completed at a prior office and you will be responsible for any non covered amount.

Regarding Insurance

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Fees

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

Missed appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

HIPAA
(Health Insurance Portability & Accountability Act)
Protecting Your Confidential Health Information is Important to Us.
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review in carefully.

Our Promise!

It is our desire to communicate to you that we are taking the new Federal (HIPPA) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxed, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws; we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission. We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between Hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentist, clinical and dental laboratories, providing you treatment.

Your Health information Rights:
The health record and billing records we maintain are the physical property of the practice. The information in it, however, belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.
- Request that you be allowed to inspect and copy your health record and billing record, you may exercise this right by delivering the request in writing to our office.
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information required to be maintained by law by delivering a written request to our office. An accounting will NOT include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorization that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact the office of Dr. Tom Gudmestad at 522 E 4th St. Weiser, Idaho 83672 (208)549-2213 in person, or in writing during normal business hours. We will provide you with assistance on the steps to exercise your rights.

You have the right to review the Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operation purposes.

OTHER DISCLOSURES AND USES:

Communication with Family:
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Dr. Tom Gudmestad
522 E 4th St
Weiser, Id 83672
(208)5499-2213

(HIPAA) Patient Acknowledgment

Patient (Please Print)
Name(s):_____

_____

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging and your review of our policy by signing this form.

_____
Patient Signature

Date_____/_____/_____