



T. 208.773.5121
F. 208.777.9484
www.optimadentalcare.com

Welcome!

We are so glad that you have chosen us to care for your dental Health. We will do everything possible to ensure that you have the most comfortable and superior dental care. We would like you to review and understand the following policies.

Payment Policy

In order to keep our fees to you as low as possible, we require your payment in full, or the portion that we estimate will not be covered by your insurance, at the time of your dental visit. We offer outside billing for your dental care through Wells Fargo Financial and Dental Fee Plan. If you wish to utilize these services, please request an application form. This application must be submitted and approved prior to your dental care visit.

Insurance Policy

If you have dental insurance that will assist you with your dental care, we will be happy to file your dental claims, provided payment is received from them within 60 days. We ask that you familiarize yourself with your insurance benefits and provide us with any changes to your policy as soon as they occur. Please remember that your insurance is a contract between you, your employer and the insurance company. Not all services are covered benefits. You are ultimately responsible for the total amount of your dental fees and you may receive an additional billing after your insurance has paid.

Collection Policy

If an account remains unpaid after several attempts to collect have been made, a \$50 collection fee will be added to the balance and the account will be turned over to a collection agency. The outstanding debt will be reported to TRW, a national credit rating service. You will be responsible for any additional fees that are incurred.

Cancellation Policy

We kindly request a *minimum of 48 hours notice* if you are unable to keep the appointment time that has been reserved for you. Sufficient notification will allow us time to provide you another appointment to ensure that you get the time that you prefer, and allows us time to invite another patient in for their dental care. We realize that emergencies do occur however, and we will be flexible under those circumstances. *Otherwise, a missed appointment fee of \$25.00 will be applied.*

For your convenience we have listed the methods of payment that we accept. Please identify the form of payment that is most convenient for you:

Cash/Check

Credit Card

Extended payment options:

Dental Fee Plan / Wells Fargo Financing

We are so happy to have you as our patient! If you have any questions regarding these policies, please don't hesitate to ask. Please sign below and return this copy to our receptionist for your file.

I fully understand and agree to abide by the above office policies.

Signed: _____ Date: _____

If you would like a copy of this document for your records, please request one from the receptionist.

HEALTH HISTORY

Are you having any pain or discomfort at this time? Yes No
 Do you smoke or use tobacco in any form? Yes No
 Have you been hospitalized in the past 2 years? Yes No
 Have you been under the care of a medical doctor during the past 2 years? Yes No
 Physician Name _____
 Address _____ Phone: _____

Have you ever been premedicated for dental work? Yes No
 Are you currently taking any medications / drugs? Yes No
 If yes, please list: _____

 Women: Are you pregnant? Yes No
 Please list any serious medical condition(s) that you have/had:

Please circle the following conditions you have:

- | | | | |
|---------------------------------|---------------------------------|-------------------------------|-----------------------------|
| Angina Pectoris | Sickle Cell Disease | Emphysema / Asthma | Fever Blisters / Cold Sores |
| Heart Disease / Attack / Stroke | Bruise Easily | Cough / Tuberculosis (TB) | Fainting / Dizzy Spells |
| Heart Failure | Hemophilia | Arthritis / Rheumatism | Epilepsy / Seizures |
| High / Low Blood Pressure | Liver Disease / Yellow Jaundice | Cortisone Medicine | Hay Fever / Sinus Trouble |
| Congenital Heart Defect | Kidney Failure/Dysfunction | Venereal Disease | Allergies / Hives |
| Heart Murmur / Rheumatic Fever | Thyroid Disease | A.I.D.S. / H.I.V. | Shingles |
| Heart Surgery | Ulcers | Hepatitis: A B C (circle one) | Nervousness |
| Heart Pacemaker | Glaucoma | Frequent Headaches | Psychiatric Treatment |
| Artificial Heart Valve | Chemotherapy / Cancer | Pain in Jaw Joint | Drug / Alcohol Addiction |
| Diabetes | X-ray / Cobalt Treatment | Artificial Joints (Hip, Knee) | Other: _____ |
| Blood Transfusion / Anemia | Cosmetic Surgery | Scarlet Fever | _____ |

Are you allergic to or have you reacted adversely to the following?

- | | |
|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antibiotics (please specify) _____ |
| <input type="checkbox"/> Codeine | _____ |
| <input type="checkbox"/> Latex | _____ |
| <input type="checkbox"/> Metals / Jewelry | <input type="checkbox"/> Local/Dental Anesthetic |

Are you aware of being allergic to any other medications or substances? If yes, please list:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying an unpaid portion that my insurance does not cover. I grant permission to submit charges for services rendered to my insurance carrier and release payment or assignment of benefits to Dr. Johnson.

Signature _____ Date _____

Medical History Update (For Office Use Only)

Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____



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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Scott Johnson Family and Cosmetic Dentistry, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Scott Johnson's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Scott Johnson Family and Cosmetic Dentistry reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Scott Johnson Family and Cosmetic Dentistry at 1296 E. Polston Ave. Ste. A., Post Falls, Idaho, 83854.

With my consent, Dr. Scott Johnson Family and Cosmetic Dentistry may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care.

With my consent, Dr. Scott Johnson Family and Cosmetic Dentistry may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Dr. Scott Johnson Family and Cosmetic Dentistry may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Scott Johnson Family and Cosmetic Dentistry restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Scott Johnson Family and Cosmetic Dentistry's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Scott Johnson Family and Cosmetic Dentistry may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date