ORME FAMILY
& IMPLANT DENTISTRY
EXPERIENCE • AESTHETICS • EXCELLENCE

Aaron G. Orme, D.D.S.

THANK YOU....FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (*Confidential*)

Name _____ Nick Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Email _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

If Student, Name of School/College _____ City _____ State _____ ☐ Full time ☐ Part Time

Patient's or Parents Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

SSN# _____ Birthdate _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check CREDIT CARD: ☐ Visa ☐ MasterCard

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do You Have Additional Insurance? ☐ **Yes** ☐ **No** ***If Yes, Complete the Following***

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

2201 E Gala St, Meridian, ID 83642
P (208) 947-4005 F (208) 888-3393

meridianidahodentist.com

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PATIENT HEALTH HISTORY

Name _____ Date _____

Physician _____ Office Phone _____ Date of Last Exam _____

	YES	NO
1. Are you under medical treatment now? If yes, please explain _____	☐	☐
2. Have you ever been hospitalized for any surgical operation or a serious illness within the last 10 years? If yes, please explain _____	☐	☐
3. Have you ever been treated for osteoporosis or bone cancer?	☐	☐
4. Have you ever taken any weight loss medication?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use any controlled substances for recreational use?	☐	☐

	YES	NO
7. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (e.g. novacain)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Others _____	☐	☐
8. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Please list any medications you are taking (including non-prescriptions medications)

Medication name(s)	Dosage/times per day	Reasons for taking

Do you have or have you had any of the following?

	YES	NO
Low Blood Pressure	☐	☐
High Blood Pressure	☐	☐
Hear Attack	☐	☐
Artificial Heart Valve	☐	☐
Heart Disease	☐	☐
High Cholesterol	☐	☐
Cardiac Pacemaker	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Murmur	☐	☐
Angina/Chest Pains	☐	☐
Rheumatic Fever	☐	☐
Circulatory Problems	☐	☐
Fainting	☐	☐
Asthma	☐	☐
Epilepsy/Seizures	☐	☐

	YES	NO
Diabetes - Type 1 OR Type 2	☐	☐
Kidney Disease/Dialysis	☐	☐
Thyroid Problem	☐	☐
Bleeding Disorder/Problems	☐	☐
Frequently Tired/Trouble Sleeping	☐	☐
Sleep Apnea	☐	☐
COPD	☐	☐
Persistent Cough	☐	☐
Emphysema	☐	☐
Seasonal Allergies	☐	☐
Tuberculosis	☐	☐
Anemia	☐	☐
Back and/or Neck Problems	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐

	YES	NO
Hepatitis/Jaundice A B C	☐	☐
Sexually Transmitted Disease	☐	☐
AIDS or HIV Infection	☐	☐
Stomach Troubles/Ulcers	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Glaucoma	☐	☐
Unexplained Weight Loss	☐	☐
Liver Disease	☐	☐
Auto Immune Disease	☐	☐
Mental Health Concerns	☐	☐
Esophageal Reflux	☐	☐

Other _____

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

Chief Dental Concern _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Do you feel pain in any of your teeth?	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Do you clench or grind your teeth?	☐	☐
7. Do you experience dry mouth?	☐	☐
8. Have you ever had any difficult extractions in the past?	☐	☐
9. Have you ever had any prolonged bleeding following extractions?	☐	☐
10. Have you undergone orthodontic treatment?	☐	☐

	YES	NO
11. Have you been treated for periodontal or "gum" disease?	☐	☐
12. Do you wear dentures or partials? If yes, date of placement	☐	☐
13. Have you ever received oral hygiene instructions regarding the care of your teeth or gums?	☐	☐
14. Are you satisfied with the current condition of your teeth?	☐	☐
15. If you could change the appearance of your teeth, what would you change? _____		

The above information is accurate to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I accept any mutually agreed upon dental anesthetics or treatment that Dr. Orme feels are necessary in my care.

Signature _____ Date _____

If no changes from prior visit: Initials _____ Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____ Date _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.**
2. **Obtain payment from insurance company or third-party payor.**
3. **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Parent/Guardian (*if patient a minor*): _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempeted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

_____

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TRUTH IN LENDING DISCLOSURE

Orme Family & Implant Dentistry is committed to providing quality dental services at a reasonable cost. It is our policy to collect all account payments at the time of services, and half down on all crowns, bridges, dentures or partial dentures. If this is not possible due to financial constraints, acceptable payment arrangements may be made by contacting our office manager or billing department. All payment arrangements must be made prior to the day of services.

In the event that an account has not closed in 60 days from the date of service, and no financial agreement has been arranged, the individual will receive final notification by letter that payment is due. If no response is received indicating a willingness to pay, the patient's account will be referred to a professional credit agency and the patient released from dental care at our facility.

As a courtesy for those patients with insurance coverage, we will file insurance regularly and in a timely manner. Additional filings for the same procedure may incur a charge of $15. However, the patient is responsible to understand the specifics of their individual insurance coverage. **The insurance contract is between the covered individual and the insurance company. The patient retains ultimate responsibility for financial charges incurred as a result of treatment.** Our staff is available for assistance with insurance billing questions during operating hours.

CANCELLATION POLICIES

Cancellation must be made at least 24 hours prior to appointment time. Failure to provide 24 hour cancellation notice may result in a fee according to the procedure and amount of time reserved for you. More than one failure to provide 24 hours notice may result in dismissal as a patient.

CREDIT TERMS

- **Payment is expected at time of service unless prior arrangements have been made.**
- **We expect that the account will be cleared within 60 days. If financial arrangements have been made, the remaining unpaid balance may be subject to a FINANCE CHARGE at the periodic rate of 1.50% per month, which is an ANNUAL PERCENTAGE RATE of 18%. We compute the FINANCE CHARGE by applying the periodic rate to the "adjusted balance" of your account. That balance is determined by taking the balance you owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle. To avoid a FINANCE CHARGE pay the "new balance" shown on your billing statement before the next billing cycle.**
- **There will be a $25 fee for all returned checks.**

I have read and I understand the above Truth in Lending Disclosure and I agree to the financial policies stated therein.

Patient Signature _____ Date _____

We accept cash, checks, Visa, and Mastercard for payment.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____
Last First Middle

_____
Maiden Name Previously Married Name Date of Birth

I hereby request and authorize: Name _____

Address _____

City _____ State _____ Zip _____

To send a copy of the following reports from the patient's record: ☐ X-Rays ☐ Perio Charting ☐ Full Dental Records

To be Released to: Orme Family & Implant Dentistry

2201 E. Gala St
Meridian, ID 83642
Fax: (208) 888-3393
Email: ormedentistry@gmail.com

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law that is applicable to ANY or ALL of the above.

My signature below authorizes release of all such information.

Signature of Patient or Responsible Party _____ Date _____

Witness _____

I, the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire upon completion of the transaction and no later than ninety (90) days from the date signed unless otherwise stated herein.

To the party receiving this information: This information has been disclosed to you form the records, whose confidentiality is protected by Federal and/or State regulation prohibit you from making further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.