Dr. Bryce D Hanson
371 W. Fir Street/PO Box 525
Shelley, ID 83274
(208) 357-7611

WELCOME!!

How did you hear about us?

- ☐ Location
- ☐ Internet Site
- ☐ Insurance List of Providers
- ☐ Family/Friend Name:

Todays Date:_____

Patient's Name:_____
Birthdate:_____Age:_____
Social Security #_____
Mailing Address:_____
City:_____State:_____ Zip_:_____

☐ Single	☐ Married	☐ Divorced
☐ Widowed	☐ Separated	☐ Child

Home Phone:_____
Cell Phone:_____
Email Address:_____
Employer (If applicable):_____
Employer Address:_____
Employer Phone: _____
How Long There: Years Month
Occupation:_____

NAME AND ADDRESS OF CLOSEST RELATIVE NOT LIVING WITH YOU

Name:_____
Address:_____
City:_____State:_____Zip_____
Phone #_____

If patient is under the age of 18, please fill out the following:

(Please Note: for children/dependents, the accompanying guardian IS the responsible party/guarantor signing for all charges for them)

Name:_____
Relationship to Patient:_____
Address:_____
City:_____State:_____Zip_____
Phone #_____
Date of Birth:_____SS#_____
Home Phone:_____
Cell Phone:_____
Email Address:_____

DENTAL INSURANCE

If you have dental insurance, we are happy to bill on your behalf for any treatment received by River Valley Dental Care. However, you will be expected to pay at the time of service any ESTIMATED portion such as copays, coinsurance or deductibles including any charges not covered by insurance. If you are not able to pay your ESTIMATED portion, you must make arrangements PRIOR to receiving treatment. You are responsible to notify us immediately if your insurance information changes. Any claims not paid after 90 days of submitting them become your sole responsibility.

Primary Insurance

Name of Insurance:_____
Address to send claims to:_____
City:_____State:_____Zip:_____
Customer Service Phone #_____
Group Number:_____
Subscriber/Member ID#_____
Subscribers Name:_____
Subscribers DOB:_____
Subscribers SS#_____
Employer:_____

Secondary Insurance

Name of Insurance:_____
Address to send claims to:_____
City:_____State:_____Zip:_____
Customer Service Phone #_____
Group Number:_____
Subscriber/Member ID#_____
Subscribers Name:_____
Subscribers DOB:_____
Subscribers SS#_____
Employer:_____

Date of Last Dental Visit / /

Name of Last Dental Provider_____

Name of Physician_____

Emergency Contact Name_____

Emergency Contact Phone #_____

Please answer the following questions:

Do you have or have you had:	**Yes**	**No**
Pain or discomfort in the mouth, face or jaw?		
Bleeding or sensitive gums?		
Aching or sensitive teeth?		
Injury to your face or jaw?		
Serious trouble associated with any previous dental treatment?		
Do you feel nervous about dental treatment?		
Have you been hospitalized in the last 2 years?		
Do you use tobacco products?		
Do you use alcoholic beverages?		
Do you use recreational or street drugs?		
Do you have allergies (i.e. itching, rash, swelling to metals, latex, aspirin, penicillin, codeine or any drugs, foods, or medications? (please circle all that apply		
High/Low blood pressure (please circle which one)		
Heart disease, heart attack, stroke, chest pain, congenital heart defect, fast or irregular heartbeat?		
Rheumatic fever or Scarlet fever?		
Artificial heart valve, pacemaker, or artificial joints?		
Do you need premedication prior to dental treatment due to a heart condition or prosthesis?		
Tuberculosis, Hemophilia, or other blood disease?		
Breathing difficulties, asthma, emphysema, hay fever or sinus trouble?		
Diabetes/low or high blood sugar?		
Thyroid disease (low or high hormone levels)?		
Stomach problems, ulcers, or irritable bowel?		
Liver disease, hepatitis, kidney disease or dialysis?		
Cancer, tumors, radiation or chemotherapy?		

Are you currently taking any prescription medications?

If yes, please list the following:

Please list any serious medical conditions you have experienced?

_____

_____

_____

WOMEN ONLY:

Are you currently pregnant: YES/NO

If yes, what is your expected due date:_____

Are you currently taking prescription contraceptive? YES/NO

Please read the following carefully

I understand that this information 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 hereby authorize River Valley Dental Care to perform the designated procedures and consent to all dental treatment indicated by sound procedures and consent to all dental treatment as indicated by sound prudent dental practices.

If the use of premedication and/or anesthetics is indicated, I consent to the administration of such as the doctors may deem advisable and proper.

MISSED/CANCELLED/LATE APPOINTMENTS

I understand that each patient is allowed to cancel within 24 hours or miss 2 appointments per calendar year without incurring a fee. Any further cancelled or missed appointments beyond 2 per calendar year will result in a charge of $35 for each appointment missed/canceled. I also understand that if I am late 10 minutes or more, my appointment may be rescheduled. It will be considered a missed appointment and will apply to above mentioned guidelines.

FINANCIAL RESPONSIBILITY

By signing my name below as the Patient and/or GUARANTOR, I accept full responsibility for payment of services rendered. I understand that I will be charged interest on all accounts that are 90 days in age at 1.5% per month (18%APR). I agree to pay all late fees ($35) Collection Costs (30% of the account balance), including reasonable attorney fees and court costs if my account becomes delinquent.

Patient/Guarantor Signature Date

(to be signed upon check in at our office)