REPSCHER DENTAL
682 SOUTH FERGUSON AVE, SUITE 3 BOZEMAN, MT 59718
406-522-8801

REGISTRATION **Date**_______________

Patient Information

Name____ Date of Birth ________________
Last *First* *Middle*
Phone # ____________________________
Soc. Sec. # _______________________
Address ____ City____________ State_____ Zip Code ________
Sex □ M □ F □ Other
Age___
□ Single □ Married □ Student □ Divorced
E-Mail Address____________________________________
Employer _______________________ Occupation_________________ Business Phone ____________
In case of emergency who do we notify? __________ Relation? _____________ Phone _________________
Who shall we thank for referring you? _______________________________

Primary Insurance

Insurance Company ____
Subscriber ID/Member ID ___________________
Group Number _______________
Policy Holder ____
Last *First* *Middle*
Birth Date of Policy Holder ____________ Soc Sec. # of Policy Holder______________
Relation to Patient ___________________
Policy Holder Phone Number _____________
Company Policy Holder is Employed By _______________________________
Occupation __________________________

Names of other dependents covered under this plan:
1. _______________________________ 2. _________________________________
3. _______________________________ 4. _________________________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____________________
Name of Insurance Company
and assign directly to Dr F. Jaeson Repscher all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

___________________________________ _________________
Responsible Party Signature Date

Release of Information To Family/Friends/Care Givers

I am authorizing the release of my dental/billing information to a trusted individual/s below. I understand that by authorizing these individuals, I am allowing them to access my records until I revoke their access. I understand that it is my responsibility to remove their access to my account if I feel it is necessary. Repscher Dental has permission to provide details about my visits to these individuals only:

- ____ ________________
  Last *First* *Phone*
- ____ ________________
  Last *First* *Phone*

Our office takes patient privacy very seriously.

Financial Agreement

We strongly feel that our patients deserve premier oral health care. Further, we fell everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our office policy.

Outside financing is available with a financial institution. We can offer our patients a 6- or 12-month loan, interest free, that allows you to make a monthly payment. The application process is simple.

Our office gladly accepts insurance. Please know that services are rendered to you and not the insurance company. We ask that our patients pay for their first visit in full at the time of service **if we cannot verify insurance**. If you have up to date xrays from a previous office, it is your responsibility to have them transferred to our office. Our office will take new xrays at your appointment if none are provided prior to your appointment.

An insurance company rarely covers the entire cost of treatment. We will do our best to estimate your deductible and the amount your insurance company will pay. Your estimated co-payment and deductible are due at the time of service and any remaining balance after your insurance has paid is your responsibility.

Account balances unpaid after 60 days will be sent to collections. Should your account be in collections you understand and agree to pay all collection costs, attorney fees and court costs.

Our office wants to provide the best care in a timely manner. We schedule time to provide care for your needs. If you need to reschedule, please call our office and we will help accommodate your needs. Please cancel within 24 hours or your appointment or your account will incur a $35.00 fee per every 30 minutes scheduled. Our office does not have to remind you of your appointment. We know that dental care is important to you and you can schedule your time appropriately.

We want you to enjoy the full benefit of your dental health.
Our office accepts cash, check, and card.

Signature: ____ Date____________

Printed Name: ____

HEALTH HISTORY FORM

Date______________

Name____ Date of Birth______________________ Age ______________

If you are completing this form for another person, what is your relationship to that person? ___________________________

Dental Information Previous Dentist____

Last Dental Visit____________ Last Dental Exam/Cleaning___________ Last Dental X-Ray_______

What is your Immediate Concern? ____

Yes	No		Yes	No	
◻	◻	Do your gums bleed?	◻	◻	Do you have head aches, earaches, neck pain?
◻	◻	Are your teeth sensitive to cold, hot, sweets or pressure?	◻	◻	Have you ever had orthodontic treatment?
◻	◻	Have you had any periodontal (gum) treatment?	◻	◻	Do you wear a removable appliance?
◻	◻	Do you clench/grind your teeth during the day or night?	◻	◻	Do you get cold sores or canker sores?

◻ ◻ Are you aware of your jaw clicking or popping while eating or yawning? How often? ____________________

◻ ◻ Have you had a serious/difficult problem associated with any previous dental treatment?

If so, explain _______________________

How do you feel about the appearance of your teeth? _______________________________________

Medical Information Primary Physician ______________________ Phone # ____________________

Yes No

◻ ◻ Are you in good health?

◻ ◻ Have there been any changes in your health within the last year? (explain) ______________________________

____

◻ ◻ Are you under the care of a physician? If so, what is/are the condition(s) being treated? ____________________

____Date of last exam ___________________________

Physicians(s) Name ____ Phone # ______________________

____ Phone # ______________________

◻ ◻ Have you had any serious illness, operation, or been hospitalized in the last 5 years? If so, what was the illness or problem? ____

◻ ◻ Do you have, or have you ever been diagnosed with a heart murmur?

◻ ◻ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

What operation(s)? _____________________________________Date(s)______________________

◻ ◻ Have you had any complications or difficulties with your prosthetic joint?

◻ ◻ Are you immune compromised?

◻ ◻ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

What antibiotic? ______________________________ What dose? _________________________________

Medications

Yes No

◻ ◻ Are you taking or have recently taken medicine(s) including non-prescription medicine(s)? If so, what medicine(s)? (please list medication name, dosage, and how often the medication is taken)

1.______________________________________ 2.____

3.______________________________________ 4.____

5.______________________________________ 6.____

◻ ◻ Do you drink alcoholic beverages? If yes, how often? ___________________________________

◻ ◻ Do you use drugs or other substances for recreational purposes? If so, how often? ______________________

◻ ◻ Do you use tobacco or nicotine products? If so, are you interested in stopping? ◻ interested ◻ not interested

Frequency of use? _____________ for __ # of years. Method of use (chew, snuff, cigarettes etc)? ___________

◻ ◻ Do you use electronic cigarettes?

Allergies Are you allergic to or have you had a reaction to:

Yes	No		Yes	No	
◻	◻	Local anesthetics	◻	◻	Latex
◻	◻	Aspirin	◻	◻	Iodine
◻	◻	Penicillin	◻	◻	Metals (jewelry)
◻	◻	Barbiturates, sedatives, or sleeping pills	◻	◻	Hay fever/Seasonal
◻	◻	Other Antibiotics________________________	◻	◻	Sulfa drugs
◻	◻	Food (specify)___________________________	◻	◻	Codeine or Narcotics
◻	◻	Other ____________________________			

If yes to any of the above, please specify type of reaction____

Women Only

Yes	No		Yes	No		Yes	No	
◻	◻	Are you or is it possible you may be pregnant?	◻	◻	Are you nursing?	◻	◻	Taking birth control pills?

General Health Information Please (X) yes or no to the following health information.

Yes No
□ □ Abnormal bleeding
□ □ AIDS or HIV infection
□ □ Anemia
□ □ Arthritis
□ □ Rheumatoid arthritis
□ □ Asthma
□ □ Blood Disease
If yes, when ________________
□ □ Cancer/chemotherapy/radiation
□ □ Cardiovascular disease
If yes, specify below:
O Angina
O Arteriosclerosis
O Artificial heart valve
O Coronary Insufficiency
O Coronary occlusion
O Damaged heart valves
O Heart attack
O Heart murmur
O High blood Pressure
O Inborn heart defect
O Mitral valve prolapse
O Pacemaker
O Rheumatic heart disease
□ □ Chest pain upon exertion
□ □ Chronic pain

Yes No
□ □ Disease, drug, or radiation-induced immunosupression
□ □ Diabetes. If yes, specify below:
O Type I (insulin dependent)
O Type II
□ □ Dry mouth
□ □ Eating disorder
If yes, when? _______________
□ □ Epilepsy
□ □ Fainting spell or seizures
□ □ G. I. reflux
□ □ Glaucoma
□ □ Hemophilia
□ □ Hepatitis, jaundice, or liver disease
□ □ Kidney problems
□ □ Low blood pressure
□ □ Mental health disorders
If yes explain:_______________
____
□ □ Malnutrition
□ □ Migraines
□ □ Night sweats
□ □ Neurological disorders. If yes, specify______________
□ □ Osteoporosis
□ □ Persistent swollen glands in neck

Yes No
□ □ Respiratory problems
If yes specify below:
O Emphysema
O Bronchitis, etc
□ □ Severe headaches
□ □ Severe rapid weight loss
□ □ Sexually transmitted disease
□ □ Sinus trouble
□ □ Sores or ulcers in the mouth
□ □ Stroke
□ □ Systemic lupus erythematosus
□ □ Thyroid problems
□ □ Tuberculosis
□ □ Ulcers
□ □ Excessive urination
□ □ Do you have any disease, condition or problem not listed? If yes explain. _____
____
____
____
____
____

Note: Both doctor and patients are encouraged to discuss all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

Signature of Patient/Legal Guardian ____**Date** _______________________
Your answers are kept confidential. This information is vital to allow us to provide appropriate care for you.

Please express below how we can best serve you as your dental health care provider:

NOTICE OF PRIVACY PRACTICE/PATIENT RIGHTS

Name: ____
Last *First* *Middle*

Our Pledge Regarding Dental Information

Our office has developed a privacy policy to make sure your health information will not be shared with anyone who does not require it. We want you to know about these policies and procedures.

How Your Health Information May Be Used

Provide Treatment: We will use your health information within our office to provide you with the best dental care possible. In addition, we may share your health information with physicians, referring dentists, clinics and labs that are providing you treatment.
Obtain Payment: We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.
Conduct Health Care Operations: Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office.
In Patient Reminders: Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care.
Abuse or Neglect: We will notify government authorities if we believe a patient is the victim or abuse, neglect, or domestic violence. We will make this disclosure ONLY when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with patient's agreement.
Public Health & National Security: We may be required to disclose to Federal officials or military authority's health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of drug treatment or medical device.
For Law Enforcement: As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or to report a crime.
Family, Friends & caregivers: We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first.
Authorization to Use or Disclose Health Information: Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.
Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restrictions preferences from our patients.
Confidential Communications: You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.
Inspect and Copy Your Health Information: You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.
Amend Your Health Information: You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. To standardize our process, please provide us with your request in writing and describe your reason for the change.
Documentation of Health Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We may need to charge you a reasonable fee for your request.
Request a Paper Copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail a copy to you. *Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information.*
I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

Signature____ Date____________

Financing Information

On qualifying purchases of $200 or more made with your CareCredit credit card account at enrolled provider locations in the CareCredit Network. Interest will be charged to your account from the purchase date if the promotional purchase is not paid in full within the promotional period. Minimum Monthly Payments required. Required monthly payments may or may not pay off purchase before end of promotional period.

The CareCredit health, wellness, and personal care credit card gives you a convenient, flexible way to pay for care for the whole family—including pets!

Scan Enjoy an easy, contactless experience.

Learn See details and options.

Prequalify Find out if you prequalify without impacting your credit score.

Apply Complete streamlined application.

Pay Use it to pay for the care you want and need.

Repscher Dental carecredit.com/go/255HVH

*No interest will be charged on the promo purchase if you pay it off, in full, within the promo period. If you do not, interest will be charged on the promo purchase from the purchase date. Any discount will reduce your total purchase amount and may result in you not satisfying the minimum qualifying purchase amount required. Regular account terms apply to non-promo purchases and, after promo period ends, to the promo balance. For new accounts: Purchase APR (interest rate) is 26.99%; Minimum Interest Charge is $2. Existing cardholders: See your credit card agreement terms. Subject to credit approval.