NORTHERN PEAKS DENTAL

A New Way of Doing Dentistry

Patient Information

First Name: _____ MI: _____ Last Name: _____ Gender: M F

Mailing Address: _____ Birthdate: _____

City/State/Zip: _____ SSN: _____

Home Phone: _____ Cell: _____ Marital Status: _____

Email: _____ Do you prefer (circle one): Texts Emails None

Please text or email a profile picture or your ID, or bring it with you to your appointment.

Phone: (208)263-7641 Email: godboltdental@gmail.com

Responsible Person (if under age 18):

First Name: _____ MI: _____ Last Name: _____ Gender: M F

Relationship to Patient: _____ Address (if different): _____

DOB: _____ SSN: _____ _____

Phone Number: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Contact's Phone Number: _____

Insurance Information:

Do you have dental insurance? Yes No

Insurance Company: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber ID/Policy #: _____ Group #: _____

Employer: _____

Please text or email us a picture of your insurance card, or bring it with you to your appointment.

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Do you have secondary dental insurance? Yes No

Insurance Company: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber ID/Policy #: _____ Group #: _____

Employer: _____

How did you hear about our office? _____

If someone referred you, who can we thank? _____

Health History

Current Family Physician: _____ Phone Number: _____

Date of Last Physical Exam: _____

Please list any current medications: _____

_____

_____

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

___ Arthritis
___ Joint Replaced/Implant
___ Organ Transplant
___ Asthma – Inhaler
___ Emphysema
___ Respiratory Problems
___ Easily Winded
___ Hay Fever/Allergies
___ Chew/Smoke Tobacco
___ Cold Sores/Herpes
___ Glaucoma
___ Stroke
___ Epilepsy
___ Dizziness
___ Fainting
___ Head Injuries
___ Mental Disorders
___ Drug/Alcohol Addiction
___ Kidney Disease
___ Diabetes
___ Liver Disease
___ Hepatitis – A or B
___ Aids/HIV
___ Cancer
___ Growths/Tumors
___ Artificial Heart Valve
___ Heart Attack
___ Heart Murmur
___ High Blood Pressure
___ Low Blood Pressure
___ Pacemaker
___ Rheumatic Fever
___ Heart Disease
___ Chest Pains
___ Anemia
___ Hemophilia
___Blood Disease
___ Blood Transfusion
___ Blood Clots
___ Pain/Noise in Jaw Joints
___ Pregnancy: Past or Present
___ Thyroid Problems
___ Stomach Problems
___ Ulcers
___ Recent Weight Loss
___ Frequently Tired
___ Radiation Treatment
___Chemotherapy
___ Other:

Do you have any allergies to any of the following:

___ Ibuprofen
___ Aspirin
___ Tylenol
___ NSAIDS
___ Penicillin
___ Amoxicillin
___ Tetracycline
___ Erythromycin
___ Zithromax
___ Azithromycin
___ Hydrocodone
___ Codeine
___ Morphine
___ Barbituates
___ Sedatives
___ Local Anesthetics
___ Iodine
___ Sulfa Drugs
___ Metals
___ Latex Rubber
___None
___ Other: Please list below

Have you taken any bone density medications such as Fosamax, Boniva, or another such as these?

Yes or No.

If yes, which medication? _____

Have you ever taken a medication for weight loss such as Fen-Phen or another?

Yes or No

If yes, which medication? _____

Have you been told you need a pre-med for treatment? If so, what pre-med was prescribed?

_____

Any other medical problems we should know about? Please expand on any medical problems here.

_____

_____

_____

_____

_____

_____

Dental History

Who is your previous Dentist? _____ Office Name: _____

When was your last dental exam? _____

When was your last cleaning? _____

Have you ever had a deep cleaning or SRP? _____

Would you like records sent over from your previous dentist? Yes No

Are you having any problems with your teeth now? Yes No

Please describe. _____

_____

_____

Personal History – Please answer yes or no and include any relevant details

Are you concerned about the appearance of your teeth?	Yes	No
Are you interested in teeth whitening?	Yes	No
Have you had any cavities within the past two years?	Yes	No
Do you avoid or have difficulty chewing on hard foods?	Yes	No
Have you had any teeth removed, including wisdom teeth?	Yes	No
Do you clench your teeth in the daytime?	Yes	No
Do you wear or have you ever worn a bite appliance?	Yes	No
Do your gums bleed when bushing or flossing?	Yes	No
Have you ever been told you have gum recession?	Yes	No
Have you ever been treated for gum disease?	Yes	No
Have you ever had braces, orthodontic treatment or spacers?	Yes	No
Do you have problems with your jaw joint? (TMJ, popping, etc.)	Yes	No

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Emerson Godbolt, D.M.D, F.A.G.D
1310 Ponderosa Drive Suite A
Sandpoint Idaho 83864
208-263-7641
Fax: 208-265-4333
godboltdental@gmail..com

HIPAA CONSENT

Please update patient information;

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

ARE WE ALLOWED TO LEAVE A DETAILED TEXT OR EMAIL MESSAGE?

YES NO

IT IS THE PATIENTS RESPONSIBILITY TO KEEP PHONE NUMBERS, EMAIL AND ADDRESSES UP TODATE. WE WILL CONFIRM VIA EMAIL, TEXT AND PHONE CALLS TO WHOM MAY WE SHARE YOUR PROTECTED HEALTH INFORMATION WITH?

NAME: _____RELATIONSHIP: _____PHONE: _____

NAME: _____RELATIONSHIP: _____PHONE: _____

NAME: _____RELATIONSHIP: _____PHONE: _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Allergies: _____

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NOTICE OF PRIVACY PRACTICES AND OFFICE POLICY

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE PRIVACY POLICY NOTICE (HIPAA) AND OFFICE POLICIES AND PROCEDURES. WE WILL ONLY USE YOUR PROTECTED HEALTH INFORMATION (PHI) FOR THE PURPOSE OF TREATMENTS, PAYMENTS, HEALTHCARE OPERATIONS, AND COORDINATION OF CARE.

I FURTHER UNDERSTAND THAT IF I FAIL TO SHOW UP FOR AN APPOINTMENT OR GIVE LESS THAN 24 HOURS NOTICE, I WILL INCUR A $50 FEE FOR EACH APPOINTMENT. BILLING FEES WILL BE APPLIED TO ANY BALANCES AGING PAST 60 DAYS.

I authorize the transfer of radiographs and dental records for the referred treatment in the event of transfer to another general dentist or dental specialist.

Photographs, x-rays, and digital images may be used for diagnosis, documentation, reference, teaching, social media, and research publication. In some instances, you may be recognizable in some of these images. Please initial the following:

_____ I authorize the use of images and radiographs for the patient listed above

_____ I DO NOT authorize the use of images and radiographs for the patient listed above

INFORMED CONSENT AGREEMENT

I give consent to receive dental treatment deemed necessary by the providers with Dr. Emerson Godbolt. These procedures include, but are not limited to examinations, oral prophylaxes, fluoride treatments, sealants, fillings, crowns, bridges, implants, dentures, periodontal treatment, extractions and the use of local anesthetic and nitrous oxide. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or in rare cases, prolonged or permanent nerve damage. This consent shall be considered in effect until rescinded or revoked in writing. I understand that if I have any questions, the team with Dr. Godbolt, will be happy to help me.

PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE

THIS DOCUMENT SHALL EXPIRE ON 12-31-2025

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DENTAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____
First **M.I.** **Last**
Patient Date of Birth: _____/_____/_____

Patient Address:

_____
Address **City** **State** **Zip**

Patient Phone Number: _____

I herby authorize and request _____
(Former Dentist's Name)
to provide

_____
Practice Name

_____
Address **City** **State** **Zip**

_____
Phone Number **email**

with copies of any and all records and information which you may have in your possession, including but not limited to the following:

- Dental records
- Diagnosis
- Dental history
- Treatment
- Radiographs

In consideration of such disclosure on the part of the above named person, I hereby release them from any and all liability arising from such disclosure.

Authorization and Signature: I authorize the release of my confidential protected dental information. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.

Signature of the Client: _____

Signature of Personal Representative: _____

Relationship of Personal Representative to Client: _____

Date of signature: _____/_____/_____