

NEW PATIENT INFORMATION:

Last Name: _____ First Name: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: ____ / ____ / ____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other

Social Security Number: _____

Employer: _____ Work Phone: _____

Insurance Information

Primary Dental Insurance Provider: _____

Subscriber's Name: _____

Subscriber's Date of Birth: ____ / ____ / ____

Relationship to Patient: _____

Subscriber ID #: _____ Group #: _____

Do you have secondary dental insurance? ☐ Yes ☐ No

If yes, please complete the following:

Secondary Dental Insurance Provider: _____

Subscriber's Name: _____

Subscriber's Date of Birth: ____ / ____ / ____

Relationship to Patient: _____

Member ID #: _____ Group #: _____

Emergency Contact

Emergency Contact Name: _____

Relationship to Patient: _____ Phone Number: _____

Previous Dental Provider

Name of Former Dental Office: _____

Dentist's Name: _____

Phone Number: _____ Email Address: _____

Approximate Date of Last Visit: ____ / ____ / ____

Referral Information

Whom may we thank for referring you to our office? _____

Please read each statement below, your signature at the bottom acknowledges acceptance of all listed policies.

Insurance and Financial Responsibility

I acknowledge that services provided under Biological Dentistry are not typically covered by most dental insurance plans. I accept full financial responsibility for all charges incurred for such services, regardless of insurance coverage or denial of benefits.

I understand that I am financially responsible for all amounts not covered by my insurance plan, including but not limited to deductibles, co-payments, co-insurance, and any remaining balances. I agree to pay all outstanding charges in full.

I understand that it is my responsibility as the patient (or legal guardian) to know and understand the terms, coverage, and limitations of my dental insurance plan. Agape Dental is not responsible for verifying or guaranteeing insurance benefits or coverage levels.

I hereby authorize direct payment of insurance benefits to Agape Dental for services rendered, including any reimbursements for care received. I understand that I remain responsible for any unpaid portion of those services.

I understand that Agape Dental will only submit claims to dental insurance plans. I acknowledge that no other types of insurance—including but not limited to medical, vision, or accident policies—will be billed on my behalf. I accept full responsibility for any charges not covered by dental insurance.

Appointments and Cancellations

I understand that a minimum of 24 hours' notice is required to cancel or reschedule an appointment. A \$75 fee will be charged for missed appointments or for appointments changed without sufficient notice.

I understand, acknowledge, and consent that dental X-rays must be taken at least once every two years in order to receive care Agape Dental. This ensures we are able to provide the most accurate diagnosis and highest standard of care.

Payment Policy

I understand that payment is due at the time of service, unless prior financial arrangements have been made. Agape Dental accepts cash, credit/debit cards, HSA/FSA, and approved third-party financing.

Returned Checks

I understand that a \$35 returned check fee will apply if a payment is declined due to insufficient funds or other banking issues.

Delinquent Accounts and Collections

I acknowledge that accounts more than 120 days past due may be referred to a collections agency. I agree to be responsible for all related administrative, legal, or collection fees incurred in that process.

Treatment of Minors

I understand that the parent or guardian who accompanies a minor to an appointment is financially responsible for payment at the time of service, regardless of custody or divorce arrangements.

Electronic Communications

I authorize Agape Dental to communicate with me via phone, text, and/or email regarding appointments, billing, or treatment follow-ups. I understand that while safeguards are in place, electronic communication may not be completely secure.

Consent to Treatment

I consent to receive dental treatment and care provided by licensed professionals at Agape Dental. I understand that I may revoke this consent in writing at any time, which will not affect treatment provided prior to the revocation.

Product Purchase Policy

I understand that all products purchased through Agape Dental are optional and made voluntarily. As such, Agape Dental is not responsible for any adverse reactions resulting from the use of these products. Additionally, for health and safety reasons, Agape Dental does not offer refunds or exchanges on any products once the packaging has been opened.

Acknowledgment and Agreement

By signing below, I confirm that I have read and understand all of the above policies and agree to abide by the terms set forth by Agape Dental.

Printed Name of Patient: _____

Relationship to Patient (if applicable): _____

Signature: _____

Date Signed: _____

Patient Consent Form – HIPAA Authorization

Agape Dental | 1613 12th Ave. Rd., Suite A, Nampa, Idaho 83686

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that I have specific legal rights to the privacy and protection of my individually identifiable health information, also known as protected health information (PHI).

By signing this form, I voluntarily authorize Agape Dental to use and disclose my PHI for the purposes of:

- Treatment – including the provision, coordination, or management of dental and related healthcare services by one or more healthcare providers;
- Payment – including, but not limited to, billing and collection activities, and disclosures to insurance companies or other third-party payers;
- Healthcare Operations – including quality assessment, training, credentialing, auditing, and administrative purposes related to the operation of Agape Dental.

I acknowledge that I have been provided access to Agape Dental's Notice of Privacy Practices, which contains a detailed description of how my PHI may be used and disclosed, as well as my rights under HIPAA. I understand that Agape Dental reserves the right to amend this Notice and that I may request a current copy at any time.

I also understand the following:

- I have the right to request restrictions on the use and disclosure of my PHI for the purposes listed above. Agape Dental is not legally required to agree to any such restrictions, but if it does, it is bound by that agreement.
- I may revoke this consent in writing at any time. Such revocation will not apply to any uses or disclosures made prior to the receipt of the written revocation.

Authorization to Release Information to Specific Individuals

In addition to the purposes above, I authorize Agape Dental to share information from my dental records, billing ledger, and/or account details with the following individual(s). This may include appointment information, diagnoses, treatment plans, billing and insurance records, and other relevant information.

Full Name, Relationship to Patient, Phone Number Access Type (check all that apply)

☐ Records ☐ Ledger ☐ Full Access

☐ Records ☐ Ledger ☐ Full Access

I understand that this authorization remains in effect unless and until I revoke it in writing.

Signature and Acknowledgment

Printed Name of Patient: _____

Relationship to Patient (if applicable): _____

Signature: _____

Date: _____

X-ray Consent/Policy Form

At Agape Dental, we are committed to providing the highest standard of dental care. As part of our comprehensive diagnostic process, **radiographic (X-ray) imaging is required at a minimum of every two (2) years**. These images are essential for accurately diagnosing and treating dental conditions that may not be visible during a clinical examination.

Consent for Radiographic Imaging

I understand that:

- Radiographic X-rays are a necessary part of my dental evaluation and ongoing care.
- These images assist in detecting cavities, bone loss, infections, abnormalities, and other dental issues that cannot be seen with a visual exam alone.
- Agape Dental follows a standard office policy that **requires updated X-rays at least every two years** for all patients to receive treatment.
- Refusal to comply with this policy may limit the dentist's ability to provide appropriate care and may result in the inability to continue treatment at this practice.

Acknowledgment and Agreement

By signing below, I acknowledge that I have read and understand the above information. I consent to receive dental X-rays as deemed necessary by the dental professionals at Agape Dental in accordance with their standard policy. I understand this consent remains valid for the duration of my care.

Patient/Guardian Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

WHOLE-HEALTH FOCUSED DENTISTRY

Dr. Yancy Sipes

DENTAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

Other family members to transfer: _____

Dental Office from Which Records Are Being Requested

Office Name:

Phone Number:

Email Address:

I, _____ (Patient's Name/Guardian), hereby authorize the release of my dental records to Agape Dental. These records may include, but are not limited to, the following: X-rays (including panoramic, bitewings, and periapical images), intraoral photographs, periodontal charting, and CBCT scans. Dental Records Released to:

Agape Dental|1613 12th Ave Rd, Ste A|Nampa|ID|83686|208-467-0079

Please email records to: INFO@AGAPEDENTALID.COM

I acknowledge and consent that, should the transferred X-rays be older than two years, updated X-rays will be required and taken at the time of my appointment.

Patient Signature : _____ Date : _____

Agape Dental – Medical Information Form

Please complete all sections accurately. This information will help us provide the best care possible. All information is confidential.

PATIENT INFORMATION

Full Name: _____

Date of Birth: ____ / ____ / ____

Gender: ☐ Male ☐ Female ☐ Other

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Cell Phone: _____

Email Address: _____

PHYSICIAN INFORMATION

Primary Care Physician: _____

Phone Number: _____

Physician's Address: _____

City: _____ State: _____ ZIP: _____

Date of Last Visit to Physician: ____ / ____ / ____

MEDICAL HISTORY

Please circle all that apply and provide additional details where necessary.

Are you currently under the care of a physician?

☐ Yes ☐ No

If yes, please provide details:

Have you been hospitalized in the past 5 years?

☐ Yes ☐ No

If yes, please describe:

Do you have any of the following health conditions?

(If YES, please circle all that apply)

- Asthma / Allergies: Asthma, Hay Fever, Use of Inhaler, Allergies to (list any known allergies): _____
 - Blood Disorders: Blood Disease, High Blood Pressure, Excessive Bleeding, Previous Blood Transfusion
 - Liver Issues: Hepatitis, Jaundice, Liver Disorder, Easy Bruising
 - Heart Conditions: Angina/Chest Pain, Heart Surgery, Heart Murmur, Stroke, Heart Valve Problems, Pacemaker
 - Endocrine Issues: Thyroid Problems, Hypothyroid/Hyperthyroid, Diabetes
 - Mental Health: Nervous Disorders, Depression, Anxiety
 - Respiratory Problems: Emphysema, Tuberculosis, Chronic Cough, Breathing Difficulties
 - Cancer: Please specify type: _____
 - Gastrointestinal: Acid Reflux, Ulcers, Colitis
 - Neurological Issues: Epilepsy, Seizures, Dizziness, Fainting
 - Joint or Bone Problems: Artificial Joint, Rheumatism, Arthritis
 - Other Conditions: (Please specify) _____
-

ALLERGIES

Please list any known allergies, including medications, food, or environmental factors.

MEDICATIONS

Please list any prescription medications, over-the-counter drugs, vitamins, or supplements you are currently taking:

If additional space is needed, please list medications on the back of this form- or give med list to the front office to scan into your chart.

TOBACCO / ALCOHOL / DRUG USE

Do you use tobacco products?

☐ Yes ☐ No

If yes, please specify:

Do you consume alcohol?

☐ Yes ☐ No

If yes, how frequently? _____

Do you use recreational drugs?

☐ Yes ☐ No

If yes, please specify: _____

SEXUAL HEALTH HISTORY

Have you ever been diagnosed with or treated for:

• HIV/AIDS ☐ Yes ☐ No

• Herpes ☐ Yes ☐ No

• Other STDs (please list): _____

CONSENT FOR TREATMENT

By signing below, I acknowledge that I have disclosed all relevant **medical** information accurately and completely to the best of my knowledge. I understand that withholding information could impact my dental treatment.

I give consent for Agape Dental to perform any necessary diagnostic procedures and treatments in connection with my dental care. I understand that I may withdraw consent at any time, except where prohibited by law.

SIGNATURES

Patient's Signature: _____

Date: ____ / ____ / ____

Guardian's Signature (if applicable): _____

Date: ____ / ____ / ____

Agape Dental Contact Information

Address: 1613 12th Ave. Rd., Suite A, Nampa, ID 83686

(208)467-0079 info@agapedentalid.com

Agape Dental – Dental Health History

Have you ever experienced any complications following dental treatments?

☐ Yes ☐ No

If yes, please provide details: _____

Do you have any health problems or conditions that may require further clarification?

☐ Yes ☐ No

If yes, please provide details: _____

In the past 2 years, have you been admitted to a hospital or required emergency dental care?

☐ Yes ☐ No

If yes, please explain: _____

Treatment Interests

Please indicate if you would like additional information on any of the following services:

- ☐ Teeth Bleaching
 - ☐ Cosmetic Dentistry
 - ☐ Dental Implants
 - ☐ Naturopathic/Biological Dentistry
-

Oral Hygiene Habits

Please indicate which of the following oral hygiene products you currently use:

- ☐ Toothbrush (Manual) ☐ Toothbrush (Electric)
 - ☐ Fluoride Rinse
 - ☐ Dental Floss
 - ☐ Other (please specify): _____
-

Type of Toothbrush Bristles

☐ Soft ☐ Medium ☐ Hard

Dental Health Concerns

Please indicate if you have experienced or currently experience any of the following symptoms:

(Circle all that apply)

- Bleeding or sore gums
 - Unpleasant taste or bad breath
 - Burning sensation on tongue or lips
 - Frequent blisters on lips or inside mouth
 - Swelling or lumps in the mouth
 - Clicking or popping of the jaw
 - Difficulty opening or closing the jaw
 - Loose teeth
 - Teeth sensitive to heat
 - Teeth sensitive to cold
 - Teeth sensitive to sweets
 - Sensitive to biting
 - Food impaction
 - Clenching or grinding teeth
 - Shifting of teeth or change in bite
-

Patient Acknowledgment

I understand that the information provided above is accurate to the best of my knowledge and will assist in determining the best treatment plan for my dental care. I acknowledge that withholding relevant information may impact on my treatment outcomes.

Patient Signature: _____

Date: ____ / ____ / ____