Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your dental Healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Personal Information

Date ______________________________

Birth date ______________________________

Soc. Sec. # ______________________________

Name ______________________________

Wishes to be called ______________________________

Male	Female

Minor	Single	Married	Divorced	Widowed	Separated

Address ______________________________

City, State, Zip ______________________________

Employer ______________________________

Occupation ______________________________

Referred by ______________________________

Responsible Party

Who is responsible for the account?

Name ______________________________

Relationship to patient ______________________________

Birth date ______________________________

Driver's License # ______________________________

Soc. Sec. # ______________________________

Address ______________________________

City, State, Zip ______________________________

Employer ______________________________

Occupation ______________________________

Work Phone ____________________ **Ext#** ______________

Home Phone ______________________________

Telephone

Home Phone ______________________

Work Phone ______________________ Ext# ____________

Cell Phone ______________________

Where do you prefer to receive calls?

Home	Work	Cell

When is the best time to reach you?

In the event of an emergency, who should we contact?

Name ______________________

Relationship ______________________

Work # ______________________

Home # ______________________

Dental Insurance Information

Primary Insurance ______________________

Name of Insured ______________________

Relationship to patient ______________________

Insured's birth date ______________________

Soc. Sec. # ______________________

Employer ______________________

Date Employed ______________________

Occupation ______________________

Insurance Company ______________________

Group # ______________________

Employee/Cert. # ______________________

Ins. Co. Address ______________________

Deductible ______________________

Amount already used ______________________

Max. annual benefit ______________________

Additional Insurance Information

Name of Insured ______________________________

Relationship to patient ______________________________

Insured's birth date ______________________________

Soc. Sec. # ______________________________

Employer ______________________________

Date Employed ______________________________

Occupation ______________________________

Insurance Company ______________________________

Group # ______________________________

Employee/Cert. # ______________________________

Ins. Co. Address ______________________________

Deductible ______________________________

Amount already used ______________________________

Max. annual benefit ______________________________

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependants.

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Signature of patient or parent if minor   Date

Financial Agreement

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full is due at each appointment.

__________ Cash

__________ Personal Check

__________ Credit Card   ________ Visa   ________ MasterCard

__________ I wish to discuss the dental office's policy

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realized that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us server your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

Dental History

Do you presently have or have you had:

#	Question	Yes	No	Unsure
1.	Pain or discomfort in the mouth face or jaws?			
2.	Bleeding or sensitive gums?			
3.	Aching or sensitive teeth?			
4.	Have you had an injury to your face or jaw?			
5.	Have you had serious trouble associated with any previous dental treatment?			
6.	Do you feel nervous or uneasy about having dental treatment?			
7.	Date of last dental treatment: ____________________			

My dental problem NOW is:

Medical History

#	Question	Yes	No	Unsure
8.	Have you been a patient in a hospital during the past two years?			
9.	Have you been under the care of a medical doctor in the past two years?			
10.	Do you use tobacco products?			
11.	Do you use alcoholic beverages?			
12.	Do you use recreational or street drugs?			
13.	Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? If so, please list:			

Drug	Dose/Frequency	Reason for Taking

#	Question	Yes	No	Unsure
14.	Do you have any allergies (i.e. itching, rash, swelling of hands, eyes, or feet), or are you made ill by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications?			
15.	Have you ever had excessive bleeding requiring special treatment?			
16.	When you walk upstairs or take a walk, do you ever have to stop because of chest pain?			
17.	Do your ankles swell during the day?			
18.	Do you use more than two pillows to sleep?			

19. Do you wake up short of breath?

DO YOU PRESENTLY HAVE, OR HAVE YOU HAD:

20. High blood pressure?
21. Heart disease, heart attack, or stroke?
22. Angina pectoris (chest pain)?
23. Heart murmur?
24. Rheumatic fever?
25. Congenital heart disease?
26. Artificial heart valve or artificial joints?
27. Fast, irregular heartbeat?
28. Pacemaker?
29. Scarlet fever?
30. Tuberculosis (TB)?
31. AIDS or HIV antibody?
32. Hemophilia, anemia or other blood disease?
33. Cold sores?
34. Venereal disease (syphilis, gonorrhea, herpes, etc.)?
35. Breathing problems, such as asthma, emphysema, hay fever, or sinus trouble?
36. Diabetes (low or high blood sugar)?
37. Thyroid disease (low or high hormone level)?
38. Are you on a special diet or have you had a significant weight change in the past year?
39. Stomach problems, ulcers, or irritable bowel?
40. Liver disease, hepatitis, or yellow jaundice?
41. Arthritis or rheumatism?
42. Mental illness, depression, epilepsy (seizure), fainting or dizzy spells?
43. Kidney disease or dialysis?
44. Cancer or other tumor?
45. Cancer treatment, such as radiation or chemotherapy?
46. Do you have a history of genetic, congenital, or family-type disorder?
47. Do you have any disease, condition or problem not listed?

48. Women:

    Are you pregnant now?

    Are you currently using a prescription-type contraceptive?

Dental Hx

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Medical Summary

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To the best of my knowledge, all of the preceding answers are true and correct.

Signature: ____________________________________
Parent or Guardian Relationship to patient

Signature: ____________________________________
Reviewing Doctor Date

Initial Vital Signs

Date: ____________________

Temp: ________________

Pulse: ________________

Resp. ________________

B.P. ________________

Height: ________________

Weight: ________________

Medical History – Physical Evaluation Update

Changes: ____

Temp: ____________

Pulse: ____________

Resp. ____________

B.P. ____________

Height: ____________

Weight: ____________

Changes: ____

Temp: ____________

Pulse: ____________

Resp. ____________

B.P. ____________

Height: ____________

Weight: ____________

Changes: ____

Temp: ____________

Pulse: ____________

Resp. ____________

B.P. ____________

Height: ____________

Weight: ____________

Dental Images

Office Financial Policies

(503) 472-2445

1. DENTAL SERVICES
Are payable at the time of the visit. As a form of payment, we accept cash, checks, MasterCard, Visa and American Express. Our returned check policy of $20.00 will be added onto the check amount for processing bank fees incurred.

Initial _________

2. INSURANCE BILLING
Patients who wish for our office to bill their insurance company we request you provide us with the necessary information in order to bill your insurance correctly. We do ask you to be responsible for any co-pays or deductible not met, as well as outstanding balances if your insurance company has not paid in 45 days from the service visit. Dental billing will be sent monthly 30 days after initial visit.

Initial _________

3. LATE APPOINTMENTS
Patients arriving more than 15 minutes late for their scheduled appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit.

Initial _________

4. MISSED APPOINTMENTS
We charge fifty dollars ($50) per hour for a missed appointment. We ask that you provide 48 hours notice for cancellation.

Initial _________

5. FINANCIAL ARRANGEMENTS
If my account is turned over to a collection agency or the hands of an attorney for collections, I will pay the doctor's attorney fees and collection costs.

Initial _________

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Patient Signature Date