

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 question or need assistance, please ask us – we will be happy to help.

Personal Information

Date: _____

Birthdate _____

Soc. Sec. # _____

Name _____

Wishes to be called: _____

Male	Female	Minor	Single	Married	Divorced	Widowed	Separated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Address _____

City, State, Zip _____

Employer _____

Occupation _____

Referred by _____

Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____

Driver's License # _____

Soc. Sec. # _____

Address _____

City, State, Zip _____

Employer _____

Occupation _____

Work Phone _____ Ext# _____

Home Phone _____

Telephone

Home Phone _____

Work Phone _____ Ext# _____

Car Phone _____

Where do you prefer to receive calls?

Home	Work	Car
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When is the best time to reach you?

Time _____ Days _____

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 birthdate _____

Soc.Sec.# _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group# _____

Employee/Cert.# _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

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 payors 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 or my dependents.

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 realize 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 serve 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:

- 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: _____

Yes	No	Unsure

My dental problem NOW is:

Medical History

- 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 with the past two years, any prescription or non-prescription drugs? If so please list:

Drug	Dose/Frequency	Reason for Taking
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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?

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- 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?

Dental Hx

Medical Summary

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

Signature _____

Patient 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 on to 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 the 15 minutes late to into their scheduled appointment may be reschedule 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 if 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 _____

Patient Signature

Date