The DENTISTS
AT ORENCO STATION

Welcome to our practice!
We thank you for choosing our team to treat you and your family.
The information on this form is important to your health and dental treatment.

PATIENT INFORMATION

TODAY'S DATE:

Patient's name ❑Dr ❑Mr ❑Mrs ❑Ms ❑Miss_____

Preferred name _____Birth date_____

Social Security #_____ Home phone _____

Home Address _____ City _____State _____ Zip _____

Mailing Address _____ City _____State _____ Zip _____

Email_____ _ Cell Phone_____

Check Appropriate Box ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If Student, Name of School/College_____ City_____ State_____ Zip_____

Patient's Employer _____ Work Phone_____

Spouse's Name_____Employer _____ Work Phone_____

Whom May We Thank for Inviting You?_____ May we contact them? ❑ Yes ❑ No

How Did You Hear About Us? ❑ Personal Invitation ❑ Professional Referral ❑ Mailer ❑ Yelp!

❑ Web Search ❑ Insurance Company ❑ Facebook ❑ Other - Please Explain_____

Emergency Contact_____Phone_____ Relationship_____

RESPONSIBLE PARTY ❑ Same as Above

Name of Person Responsible for this Account_____Birthdate_____

Relationship to Patient_____ Social Security #_____

Home phone_____ Cell Phone_____Email_____

Home Address _____ City _____State _____ Zip _____

Mailing Address _____ City _____State _____ Zip _____

Employer _____ Work Phone_____

INSURANCE INFORMATION ❑ Not Covered by Dental Insurance

Name of Insured_____ Relationship to Patient_____ Birthdate_____

Social Security Number: _____ Employer_____

Dental Insurance Co._____ Group number_____ Policy ID Number_____

Union or Local #_____ Dental Insurance Phone Number: _____

Claims Address _____ City _____ State _____ Zip _____

How Much is Your Deductible?_____How Much Have You Used?_____ Max. Annual Benefit_____

Do You Have Any Additional Insurance? ❑ yes ❑ no If Yes, Complete the Following

Name of Insured_____ Relationship to Patient_____ Birthdate_____

Social Security Number: _____ Employer_____

Dental Insurance Co._____ Group number_____ Policy ID Number_____

Union or Local #_____ Dental Insurance Phone Number: _____

Claims Address _____ City _____ State _____ Zip _____

How Much is Your Deductible?_____How Much Have You Used?_____Max. Annual Benefit_____

OVER PLEASE

MEDICAL HEALTH HISTORY

PATIENT NAME:_____

Physician _____ Office Phone _____ Date of Last Exam _____

	Y	N
1. Are you under medical treatment now? If yes, please explain _____	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years If yes, please explain _____	❑	❑
3. Are you taking any medication(s) including non-prescription drugs? If yes, what are the medications? _____	❑	❑
4. **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑
Date_____ Any complications?	❑	❑
5. Do you use controlled substances?	❑	❑
6. Do you use tobacco products?	❑	❑
7. Do you have a persistent cough or throat clearing associated with a known illness (lasting more than 3 weeks)?	❑	❑

	Y	N
8. Are you taking or scheduled to take alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	❑	❑
9. Have you been treated or scheduled to be treated with IV bisphosphonates (Aredia or Zometa) for bone pain hypercalcemia, Paget's disease, multiple myeloma or metastatic cancer?	❑	❑

10. Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex rubber
- ❑ Local anesthetics (e.g. Novacaine)
- ❑ Penicillin or other antibiotics
- ❑ Metals (e.g. nickel, mercury, etc)
- ❑ Codeine or other narcotics
- ❑ Animals
- ❑ Food
- ❑ Other_____
- ❑ Barbituates
- ❑ Sedatives
- ❑ Sulfa drugs
- ❑ Iodine
- ❑ Aspirin
- ❑ Hay fever/seasonal

WOMEN ONLY Are you:	Y	N
Pregnant?	❑	❑
Number of weeks_____		
Taking birth control pills or hormone replacement?	❑	❑
Nursing?	❑	❑

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

	Y	N
Artificial (prosthetic) Heart Valve	❑	❑
Previous Infective Endocarditis	❑	❑
Damaged Valves in Transplanted Heart	❑	❑

Congenital Heart Disease (CHD)	Y	N
Unrepaired, Cyanotic CHD	❑	❑
Repaired completely in last 6mos	❑	❑
Repaired with residual defect	❑	❑

Except for the conditions listed above, antibiotic prohpylaxis is no longer recommended for any other form of CHD.

	Y	N		Y	N		Y	N
High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains	❑	❑
Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded	❑	❑
Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Swollen Ankles	❑	❑	Angina	❑	❑	Autoimmune_____	❑	❑
Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis	❑	❑
Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Epilepsy/Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss	❑	❑
Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease	❑	❑
Diabetes Type I or II	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble	❑	❑
Kidney Disease	❑	❑	Hepatitis/Jaundice	❑	❑	Respiratory Problems	❑	❑
AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Mitral Valve Prolapse	❑	❑
Thyroid Problem	❑	❑	Stomach Troubles/Ulcers	❑	❑	Other _____	❑	❑

DENTAL HISTORY

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

Reason for Today's Visit _____

	Y	N
Do your gums bleed while brushing or flossing?	❑	❑
Are your teeth sensitive to hot or cold liquids?	❑	❑
Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
Do you feel any pain in your teeth today?	❑	❑
Do you have any sores or lumps in or near your mouth?	❑	❑
Have you had any head, neck or jaw injuries?	❑	❑
Have you ever experienced any of the following problems in your jaw:		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑

	Y	N
Do you have frequent headaches/earaches?	❑	❑
Do you clench or grind your teeth?	❑	❑
Do you bite your lips or cheeks frequently?	❑	❑
Have you ever had difficult extractions in the past?	❑	❑
Have you ever had prolonged bleeding following extractions?	❑	❑
Have you had any orthodontic treatment?	❑	❑
Do you wear dentures or partials?	❑	❑
Date delivered_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑
Do you like your smile?	❑	❑

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or 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 dependants.

X _____

Signature of Patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____Signature _____Date_____

BP: _____Pulse:

The DENTISTS
AT ORENCO STATION

1322 NE Orenco Station Parkway ● Suite 300 ● Hillsboro, OR 97124 ● www.DentistsAtOrenco.com

Statement of Financial Policy

Our office is committed to providing you and your family the highest quality dental care available. In order to achieve this goal we seek your understanding of, and compliance with, our payment policy.

Payment is due at the time services are rendered. We accept American Express, VISA, MasterCard, Discover credit cards, Care Credit, debit cards, cash and checks.

As a courtesy to our patients who have dental insurance, we will file claims and accept payment directly from your insurance company. Since most procedures are not covered at 100%, we require your payment of the estimated portion not covered by your insurance company at the time of treatment. Please keep in mind the following:

A) Not all services are covered benefits in all contracts. Benefits may vary not only from plan to plan, but from patient to patient. Please familiarize yourself with your insurance coverage. A phone call to the information number on your insurance card to review the benefits applicable to your treatment plan is recommended.

B) Your copayment is due in full at the time of service. We will call your insurance company prior to your initial visit to get an estimate of what your insurance will cover; however, the insurance company will state that **the quote over the phone is not a guarantee of benefit.**

C) Insurance may pay for all, some, or none of your bill; you are immediately responsible for any portion not paid by your insurance company irrespective of estimates. Please note that your insurance company may base its payment on a fee that they have designated for a procedure, rather than our fee. That fee is typically below our fee, resulting in non-payment of a portion of the claim. If you would like to confirm, prior to commencing treatment, your insurance company's precise participation in any or all of the procedures on your treatment plan, please specify to our front office team members those procedures you would like to have us preauthorize with your insurance company. Preauthorization's can take up to 30 days, and are valid for a limited time period.

D) Accounts that are 60 days old are considered delinquent. A finance charge of $3.00 per month or interest of 1-1/2% per month (whichever is greater) will be added to cover the cost of additional handling. Checks returned for insufficient funds, closed accounts or other problems are subject to a $50.00 service fee. Accounts subject to collection activity will be charged an additional handling fee.

E) Payment for any appointment with treatment costs larger than $1500.00 copayment will need to be made at the time of scheduling the appointment. Payment for any sedation appointment will be paid in full 7 days prior to the confirmed appointment time and day. Failure to make payments will result in a cancelation of the appointment. If for any reason you fail to make your confirmed appointment we reserve the right to keep 10% of the appointment fee. A $50.00 deposit will be required for all Scaling and Root Planing appointments. Failure to show to your appointment will result in a forfeit of the $50.00 deposit.

We must emphasize that as dental care providers, our relationship is with you rather than your insurance company. We are not responsible for constraints, discrepancies, or disputes resulting from the relationship between the patient and his or her insurance provider. Rather, the focus of our relationship with each and every one of our patients is to provide the highest quality dental care available. To that end, we look forward to caring for you!

Patient's Name _____ Relationship to Patient _____

Signature _____ Date: _____

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PATIENT APPOINTMENT AGREEMENT

We make every effort to value your time and schedule your appointment time just for you.

We truly appreciate your courtesy of giving us 48 hours notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

- I acknowledge my appointment is a reservation.
- I acknowledge I am required to provide 48 hours notice to make any changes to my appointment.
- I acknowledge after my first missed appointment I may be required to leave a $50.00 deposit in order to schedule my next appointment.
- I acknowledge that if I fail to give sufficient notice to change my rescheduled appointment or I fail to show to my appointment, that I may forfeit my deposit of $50.00.
- I acknowledge if for any reason I fail to make my confirmed appointment for either sedation or treatment over $1500.00, that I may forfeit 10% of treatment cost.
- I acknowledge that a $50.00 deposit will be required for all Root Planing and Scaling appointments. If for any reason I fail to show to my appointment I will forfeit my deposit.

_____
Patient Name

_____
Patient Signature

_____
Date

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* You May Refuse to Sign This Acknowledgment *

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: (503) 640-4262

Email Address (PLEASE PRINT CLEARLY):

_____

- ❑ I decline electronic communication.

Patient Signature:_____

Date:_____