PATIENT FORM

PATIENT INFORMATION

Patient Full Name ______________________ Preferred Name ______________

Marital Status: Single Married Child Other Birthdate ____/____/________ Patient SS # / or DL # ______________

Home Phone________________ Cell Phone____________________ Work Phone________________

Mailing Address ____

City ________________ State ________________ Zip Code ________________

IF PATIENT IS UNDER 18 (please complete this section)

Who is responsible for this account? ______________________Relationship to patient ______________

SS # ______________ Birthdate ___/___/______ Employer____________________

Mailing Address (if different from above) ________________________________

City ____________ State ________ Zip Code __________ Cell Phone ______________

EMERGENCY CONTACT INFORMATION:

Name ______________________ Relationship to you ____________ Phone ______________

DENTAL INSURANCE INFORMATION

Primary

Insurance Company ______________________ Insurance Company Phone ______________

Group # ______________ID # ______________ Subscriber's Name________________

Subscriber's Employer ____________________ Subscriber's Birthdate _____/_____/_____

Subscriber's SS# ______________ Relationship to Patient ______________

Secondary

Insurance Company ______________________ Insurance Company Phone ______________

Group # ______________ID # ______________ Subscriber's Name________________

Subscriber's Employer ____________________ Subscriber's Birthdate _____/_____/_____

Subscriber's SS# ______________ Relationship to Patient ______________

REFERRAL INFORMATION: How did you hear about our office? Please check the box [x] next to any that apply:

[ ] Referred by a Friend: (Name of Friend) ______________________________

[ ] Location

[ ] Website/Internet

[ ] Brochure/Newspaper

[ ] Social Media (Facebook/Twitter/)

[ ] Other: ______________________

MEDICAL HISTORY

Patient Full Name ______________________

Cell Phone ______________________

1. Are you currently experiencing pain or discomfort? .... [Y] YES [N] NO
2. Do you feel very nervous about having dental treatment? .... [Y] YES [N] NO
3. Have you been hospitalized in the past 2 years? .... [Y] YES [N] NO
4. Have you been under a doctor's care in the past 2 years? (other than routine) .... [Y] YES [N] NO
   Nature of care ______________________ Physician's Name ______________________
5. Are you currently taking any medications? .... [Y] YES [N] NO
   If so, please list: ______________________
6. Are you currently taking Blood Thinners? .... [Y] YES [N] NO
7. Are you allergic to or have a sensitivity to any of the following? **Please Check the Box** [Y] YES or [N] NO next to **EACH**:

[Y] [N] Sulfa	[Y] [N] Acetaminophen (Tylenol)	[Y] [N] Hydrocodone (Vicodin)
[Y] [N] Penicillin/Amoxicillin	[Y] [N] Ibuprofen (Advil)	[Y] [N] Oxycodone (Percocet)
[Y] [N] Clindamycin	[Y] [N] Lidocaine (Xylocaine)	[Y] [N] Metal Allergy: Type ________
[Y] [N] Erythromycin	[Y] [N] Novacaine	[Y] [N] Other: Type ________

8. **Please Check the Box** [Y] YES or [N] NO next to **EACH** you currently have or have had previously:

[Y] [N] Acid Reflux/GERD	[Y] [N] Eating Disorder	[Y] [N] Sleep Apnea
[Y] [N] Alzheimer's/Dementia	[Y] [N] Epilepsy	[Y] [N] Snoring
[Y] [N] Anemia	[Y] [N] Fainting/Dizzy Spells	[Y] [N] Stroke
[Y] [N] Arthritis	[Y] [N] Hemophilia	[Y] [N] Thyroid Problems
[Y] [N] Artificial Joints – Surgery Date ______ Type ______	[Y] [N] Hepatitis Type ______	[Y] [N] Tobacco Use
[Y] [N] Asthma	[Y] [N] HIV/AIDS	[Y] [N] Tuberculosis
[Y] [N] Autoimmune Disease Type ______	[Y] [N] Jaw pain/Jaw Joint (TMJ) Pain	[Y] [N] Heart Disease
[Y] [N] Bisphophonate Use (Fosemax, Reclast, Boniva)	[Y] [N] Kidney Disease	[Y] [N] High Blood Pressure
[Y] [N] Cancer/Tumor Type ______	[Y] [N] Liver Disease	[Y] [N] Angina Pectoris
[Y] [N] Chemotherapy/Radiation Therapy	[Y] [N] Marijuana Use	[Y] [N] Heart Attack
[Y] [N] Cold Sores/Fever Blisters	[Y] [N] Mental Health Disorder	[Y] [N] Congenital Heart Defect
[Y] [N] Diabetes I or II	[Y] [N] MRSA Infection	[Y] [N] Pacemaker
[Y] [N] Insulin Pump	[Y] [N] Osteoporosis	[Y] [N] Artificial Heart Valve
[Y] [N] Drug/Alcohol Addiction	[Y] [N] Respiratory Problems	[Y] [N] Other: ________

8. Have you been advised to take antibiotics before dental treatment? .... [Y] YES [N] NO

WOMEN ONLY

Are you pregnant? [Y] YES [N] NO Month? ________

RESPONSIBLE PARTY CONSENT

I, the undersigned certify that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I, the undersigned Hereby authorize Silverton Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time of services are rendered. I agree to pay a 1.5% per month finance charge on all accounts 60 days past due. I will give 24 hours notice if I am unable to keep an appointment. Otherwise, I am responsible for any "broken appointment" fee that may be charged.

______________________ ______________________ ______________________

Responsible Party Signature Relationship Date

SILVERTON FAMILY DENTISTRY

303 N. First Street, Silverton, Oregon 97381

Notice of Privacy Practices Acknowledgement and Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed and have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but, if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

May we phone (leave a message), email, or text to conform appointments? YES NO

May we leave a message on your answering machine regarding treatment or financial information? YES NO

May we discuss your medical condition with any members of your family? YES NO

If YES, please name the member(s) allowed: ____________________

Patient Name ____________________

Relationship to Patient ____________________

Signature ____________________

Date ____________________

Financial Policies

Insurance:

We are dedicated to providing you with the best possible dental care. To give our patients this level of customer service will require that we have some financial and insurance policies. It is important that you read carefully and understand each of the following statements.

Charges:

We help file your insurance claims as a courtesy and a convenience to you.

Your insurance coverage is a contract between you, your employer and the insurance company.
We are not a party to this contract.
Our relationship is with you and not with your insurance company.
All charges are your responsibility.

Our office will submit your dental claims to your first and if applicable your secondary insurances as a courtesy. It is your responsibility to provide us with the correct current insurance information and to understand your benefits. It is also your responsibility to monitor what has been paid out from your insurance company per benefit year, should you be close to using up your benefits. It is also your responsibility to confirm that the doctor you are seeing is on your insurance provider list and to obtain referrals if necessary.

We require all deductibles and co-payment to be made at the time of service. We have no control over what your insurance company will or will not choose to pay. We will estimate your dental treatment to the best of our ability. However, all charges for treatment are ultimately the patient's responsibility.

Appointments:

There will be a charge of $50 per hour of appointment time if you are not able to give the office a 24-hour notice of cancellation.

I grant permission to the staff to telephone me at **home, work or on my cell** to discuss matters related to this form. I have read, understand and agree to the policies listed above. (minors must have signature of parent or guardian before being seen)

Signature ____ Date__________________________