W E L C O M E

We are pleased to welcome you to our practice. Please take a few minutes to fill out the following forms as completely as you can. If you have any questions, we will be happy to help you. We look forward to working with you in maintaining your dental health.

Kip L. Hampton, DDS, PC

Patient Information

PLEASE COMPLETE ALL PAGES

Patient Name | Date of Birth

Address | City | Zip code

Phone | Social Security #

If patient is a minor, Parent or Guardian's name

Responsible Party Information

Name | Relationship to pt.

Address | City | Zip code

How long at this address? | Phone | Date of Birth

Social Security # | Employer | Occupation | How long?

Spouses name | Relationship to pt.

Social Security# | Employer | Occupation | How long?

Insurance Information

Insured's name | Social security # | Date of Birth

Insurance Company | Group # | Local #

Insurance Company's address | Dual coverage?

Insured's name | Social security # | Date of Birth

Insurance Company's address

Emergency Contact

Contact name | Phone | Relationship to patient

Dental History

Patient name_____ Date of birth_____
What would you like us to do today?_____ Discomfort?_____
Former Dentist _____ Phone _____
Date of last dental exam_____ Radiographs_____
Please circle if you have any of the following:
Bad breath Food collection between teeth Periodontal treatment Sensitive to sweets
Bleeding gums Grinding/clenching Sensitive to hot/cold Sensitive when biting
Clicking or popping jaw Loose teeth/broken fillings Sores/growths in mouth
How often do you brush?____ Floss?____
Have you ever experienced an adverse reaction during or in conjunction to a dental or medical procedure? _____
If yes, Please explain:_____
Other information about your dental health or previous treatment _____
_____

Medical History

Physician's name_____Address_____Phone_____
Date of last visit_____ Please list any past surgeries or hospitalizations _____
Have you ever had a blood transfusion_____ If yes, when?_____
Women: Are you pregnant?_____ Nursing?_____ Taking contraceptives?_____

Please circle if you have any of the following:

AIDS	Persistent cough	HIV positive	Shortness of breath
Anaphylaxis	Cough up blood	Jaw pain	Skin rash
Anemia	Diabetes	Kidney disease	Spina Bifida
Arthritis	Epilepsy	Liver disease	Stroke
Artificial heart valves	Fainting	Material allergies (latex, wool,	Surgical implants
Artificial joints	Food allergies	metal, chemicals)	Swelling of ankles or feet
Asthma	Glaucoma	Mitral valve problems	Thyroid disease
Atopic	Headaches	Nervous problems	Tobacco habit
Back problems	Heart murmur	Pacemaker	Tonsillitis
Blood disease	Heart problems	Psychiatric care	Tuberculosis
Cancer	Describe_____	Rapid wt. loss or gain	Ulcer
Chemical dependency	Hemophilia	Radiation treatment	Venereal disease
Chemotherapy	Herpes	Respiratory disease	
Circulatory problems	Hepatitis	Rheumatic/Scarlet fever	
Cortisone treatments	High blood pressure		

Current medications:_____
_____
Allergies:_____
Pharmacy:_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and helpful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for any charges whether or not paid for by insurance. Payment is due in full at time of service. All unpaid balances will be subject to a 1 ½ % per month at 18%per year finance charge.

_____ _____
Signature **Date**

Are you currently or have you in the past taken any of the following medications for Osteoperosis/Osteonecrosis? If your answer is yes to any, please include the date that treatment began.

DIDRONEL=ESTRONATE Y___ N___

ACTONEL=RISEDRONATE Y___ N___

FOSAMAX=ALANDRONATE Y___ N___

BONIVA=IBANDRONATE Y___ N___

ARDENDIA=PAMIDRONATE Y___ N___

ZOMETA=ZOLEDRONATE Y___ N___

Date Treatment Began: _____

_____ _____
Patient or Representative Signature Date

Consent

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis for the patients dental needs. I also authorize and consent for the Doctor to use local anesthetic and I understand the use of local anesthetic agents embodies a certain risk.

_____ _____
Patient Name **Date**

_____ _____
Signature **Relationship to Patient**

Consent Update

_____ _____
Date Date
_____ _____
Procedure Procedure
_____ _____
Signature Signature

_____ _____
Date Date
_____ _____
Procedure Procedure
_____ _____
Signature Signature

Siskiyou Dental Associates
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

_____ **(IF PT IS A MINOR, PARENT/GUARDIAN MUST SIGN)**
Patient Name

Section B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and health care operations, of the uses of disclosures we may make of your protected health information and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent.
You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice at any time by contacting:
Michelle Peltier- 2665 Siskiyou Blvd. Medford, OR 97504 (541)282-5523

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you, or continue to treat you if you revoke this Consent.
I have had the opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing the consent form, I am giving my consent to your disclosure of my protected health information to carry out treatments, payment activities and health care operations.

_____ _____
Signature **Date**
If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

_____ _____
Representative's Name **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I have received a copy of this office's Notice of Privacy Practices to review

_____ _____
Print Name **Date**

_____
Signature

For Office Use Only
We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice's. Acknowledgement could not be obtained because:
_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ an emergency situation prevented us from obtaining acknowledgement
_____ other (Please specify) _____