



THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed

If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

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 _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

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

Over Please

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

Yes No

- Are you under medical treatment now? Yes No
- Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
If yes, please explain _____
- Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medication(s) are you taking? _____
- Have you ever taken Fen-Phen/Redux? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No
- Are you wearing contact lenses? Yes No
- Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
- Are you allergic to or have you had any reactions to the following:

Local Anesthetics (e.g. Novocain)	Yes	No
Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
- Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes No
- Women Only:

Are you pregnant or think you may be pregnant?	Yes	No
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

Yes No

- Do your gums bleed while brushing or flossing? Yes No
- Are your teeth sensitive to hot or cold liquids/foods? Yes No
- Are your teeth sensitive to sweet or sour liquids/foods? Yes No
- Do you feel pain to any of your teeth? Yes No
- Do you have any sores or lumps in or near your mouth? Yes No
- Have you had any head, neck or jaw injuries? Yes No
- Have you ever experienced any of the following problems in your jaw?

Clicking	Yes	No
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>
- Do you have frequent headaches? Yes No
- Do you clench or grind your teeth? Yes No
- Do you bite your lips or cheeks frequently? Yes No
- Have you ever had any difficult extractions in the past? Yes No
- Have you ever had any prolonged bleeding following extractions? Yes No
- Have you had any orthodontic treatment? Yes No
- Do you wear dentures or partials? Yes No
If yes, date of placement _____
- Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
- Do you like your smile? Yes No

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 dependents.

X
Signature of patient (or parent/guardian if minor) _____

Doctor's Comments _____

Signature _____ Date _____

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 by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 below 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.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

The Dentist At Orenco Station, PC
James Row, DMD
1322 NE Orenco Station PKWY, Suite 300
Hillsboro, OR 97124
(503) 640-4262

Statement of Financial Policy

Our office is committed to providing "State of the art dental care for the quality of life your family deserves." 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 cash, VISA, MasterCard, and Discover credit cards, debit cards, 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 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 before 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 nonpayment 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 Becki those procedures you would like to have us preauthorize with your insurance company. Preauthorizations can take up to 30 days, and are valid for a 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) All appointments require a 48 hour notice of cancelation. If you do not cancel your appointment within the 48 hour window you are subject to a \$50.00 cancelation fee.

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!

Sincerely,

James Row, DMD & Staff

Patient's Name _____ Patient's Signature _____ Date: _____