WHITE HOUSE DENTAL
BERNT E. WHITE, D.M.D.
RICHARD R. WHITE, D.M.D.
347 West Idaho Avenue
Ontario, Oregon 97914

(541) 889-8837
whitehousedentistry@gmail.com
whitehousedental.net

Welcome to our office! Please help us by filling out the following form with your dental/health history and billing information. Thank you!

Patient Information:

Name: ______________________________ Date: ______________
Mailing Address: ______________________________
City: ______________ State: ________ Zip: ______________
Home Phone: ______________ Work Phone: ______________
Cell Phone: (_____) ______________ Email Address: ______________
Confirm appointment by text? Yes_______ No_______
If yes, what phone carrier do you have? (Example: Sprint/Verizon/Alltel): ______________
How would you prefer to be contacted for Appointment reminders?
☐ Text ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail

Date of Birth: ______________ Soc. Sec. #______________
Marital Status: married single Sex: male female
Your Employer: ______________________________
You're Employer Address: ______________________________
Spouse Name: ______________ Spouse Employer: ______________

Primary Insurance:
Person Responsible for Account:
Name: ______________________________
Mailing Address: ______________________________
City: ______________ State: ________ Zip: ______________
Home Phone: ______________ Work Phone: ______________
Date of Birth: ______________ Soc. Sec. #______________
Employer: ______________________________
Employer Address: ______________________________
Dental Insurance Co.: ______________________________
Address: ______________________________

Additional Insurance:
Is patient covered by additional insurance YES NO
Subscriber Name: ______________________________
Relationship to Patient: ______________ Employer: ______________
Address (if different from patient) ______________________________
City: __________ State: __________ Zip: __________ Phone: __________
Soc. Sec #: ______________ Date of Birth: ______________
Insurance Company: ______________________________

Financial Responsibility:
As a courtesy to our patients, we will submit dental claims for insurance payment. Please be aware, however, that in the event your insurance company does not cover charges incurred, the **responsible party will be held liable for the balance owing on the account.** In case your dental insurance coverage has changed, please be sure to update us with your current dental insurance information! If you are not covered by an insurance you are responsible for the bill at each appointment.

Method of Payment:
Payment is due at time of service. Methods of Payment our office accepts are: **Cash, Personal Check, Money Order, VISA/Mastercard, and CareCredit. We also have a payment plans that allows you to start treatment today with no down payment, and spread payment over time.** You need to apply for the payment plans we have CareCredit and Citi Health Card, if you would like to apply please as for application. If you are covered by Dental Insurance, you are responsible for your percentage at the time of service and we will bill the insurance for the balance. Our bills will go out every month if your balance is 60 days past due you will automatically receive a finance charge of 1.5%. (Please read **Financial Responsibility** paragraph above.)
Any other financial arrangements MUST be made PRIOR to treatment!

Authorization:

I hereby authorize payment of my dental insurance benefits otherwise payable to me to Dr. Richard White/Dr. Bernt White. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Richard White/Dr. Bernt White to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page are correct to the best of my knowledge.

Signature of Responsible Party: ______________________________

Date: ______________________________

Health information and History

Patients Name: ______________________________ Date: ______________
Emergency Contact: ____________________Phone:_________ Relationship: __________
Primary Physician: _____________________Phone:_________ City & State: __________
Are you under a doctors care now? (describe): ______________________________

	Yes	No
1.) Have you been hospitalized or had surgery in the last 3 years?	___	___
Explain: ______________________________		
2.) Have you been instructed to take any medication or take any special precautions, before any dental appointments?	___	___
3.) Are you taking any drugs, medication or having treatment at this time?	___	___
Please list: ______________________________		
4.) Are you allergic to any medications, drugs or treatment?	___	___
Please list: ______________________________		
5.) Are you allergic to Latex?	___	___
6.) Are you taking or have you taken a Bisphosponate (Fosamax)?	___	___
7.) Are you pregnant? (Women)	___	___
8.) Are you currently taking any anti-depressants?	___	___
If yes, please list: ______________________________		

Please circle if you have any of the following:

Scarlet fever	Low Blood Pressure	Mitral Valve Prolapse
Arthritis/Gout	High Blood Pressure	Parathyroid Disease
Rheumatic Fever/heart disease	Frequent Cough	Bruise Easily
Pacemaker	Tuberculosis	Thyroid Disease
Emphysema/lung disease	Excessive Thirst	Rheumatism
Blood Disease	Liver Disease	Pain in Jaw Joints
Anemia	Hepatitis A	Cortisone Medication
Shortness of Breath	Hepatitis B	Glaucoma
Swelling of Feet/Ankles/Hands	Hepatitis C	Epilepsy or Seizures
Yellow Jaundice	Hypoglycemia	Drug Addiction
Recent Weight Loss	Chest Pain	Blood Transfusion
Dizziness	Heart Trouble	Hemophilia
Lung Disease	Skin problems	AIDS/HIV
Diabetes	Heart Defect	Venereal Disease
Heart Murmur	Herpes	Active STD's
Kidney Trouble	Stroke/CVA	Cancer
Ulcers/Acid reflux	Artificial Heart Valve	Chemotherapy
Sinus Trouble	Allergies	Radiation
Alzheimers or Dementia	Osteoporosis	Atherosclerosis
Congestive heart failure	Coronary artery disease	Heart attack When_________
Heart surgery When _________	Excessive bleeding	Organ Transplant
Asthma	Light Sensitivity	Dry Mouth
Mental Health Issues	Artificial Joints What joint_________ When_________	

8.) Do you have any other conditions, diseases, or medical problems not listed? Yes No

____

____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at my next appointment without fail.

Signature ______________________________ Date____________________

Dental and Oral Health Information

Do you have any specific dental problems or discomfort at this time? ______________________

____

Previous Dentist's name: ____________________________ City & State: ____________________

Date of your last dental exam: _____________X-rays: _____________Cleaning:_____________

Who referred you to our office? ____

Are you nervous about dental treatment?____

Do you brush and floss on a routine basis? ____

Are you using an electric or regular tooth brush? ____

Do your gums bleed when you brush? ________ If Yes Describe: _________________________

Are your gums red, swollen, tender, or sore? ____

Do you have gums that have pulled away from the teeth? ________________________________

Do you clench or grind your teeth? ____

Do you have any clicking, snapping or difficulty when chewing? ________________________

Do you have difficulty opening or moving your jaws? ___________________________________

Do you have loose or separating teeth? ____

Do you have any color change of the tissues in your mouth? ____________________________

Do you have pain, tenderness, numbness, or earaches? __________________________________

Do you wear any removable dental appliances? ____

If yes, what type and for how long? ____

How do you feel about the appearance of your smile and what would you change if you could?

____

Have you ever had any complications from an extraction or dental treatment? ______________

If yes, please explain: ____

Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth? _________________

If yes, please specify: ____

Tobacco Questions

Smoking status: (Circle one)

Never Previous Current

How much per day? ____________________

How long have you smoked? _____________

Would you like to quit? _________________

Chewing Status: (Circle one)

Never Previous Current

How much per day? _______________

How long have you chewed? _________

Would you like to quit? _____________

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at my next appointment without fail.

Signature ____ Date ____________________

WHITE HOUSE DENTAL
BERNT E. WHITE, D.M.D.
RICHARD R. WHITE, D.M.D.
347 West Idaho Avenue
Ontario, Oregon 97914

(541) 889-8837
whitehousedentistry@gmail.com
whitehousedental.net

I, ______________________________, acknowledge that I have received or can obtain a copy of this office's Notice of Privacy Practice. I understand that by signing this Consent form, I am giving my consent to your use and discloser of my protected health information to carry out treatment, payment activities, and health care operations.

____
Signature

____
Date

If you are over the age of 18 please list anyone who you will allow us to discuss your treatment with. (Parents, Guardians, Family etc.)

_________________________ _________________________

_________________________ _________________________

Declinations

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please Specify)

____

____