**THIS FORM MUST BE FULLY COMPLETED BEFORE SERVICES WILL BE PROVIDED**
**ALL INFORMATION WILL BE VERIFIED**

## PATIENT INFORMATION

Name: (First, Middle, Last) _____ Spouse: _____

Birth Date: _____ Social Security #: _____ Sex: M F Single Married Divorced Separated

Address: _____ Apt: _____ City: _____ St.: _____ Zip: _____

Primary Phone: _____ Work: _____ Alternative: _____

ODL/State ID: _____ Email Address: _____

## Insured Person or Responsible Party or Cosigner

Name: (First, Middle, Last) _____ Relationship to Patient _____

Birth Date: _____ Social Security #: _____ Sex: M F Single Married Divorced Separated

Address: _____ Apt: _____ City: _____ St.: _____ Zip: _____

Primary Phone: _____ Work: _____ Alternative: _____

ODL/State ID: _____ Employer: _____

Address: _____ City: _____ St.: _____ Zip: _____

Insurance Co. Name: _____ Policy/Group #: _____ St. Program ID #: _____

## 2nd or Co-insurance - If applicable

Name: (First, Middle, Last) _____ Spouse _____

Birth Date: _____ Social Security #: _____ Sex: M F Single Married Divorced Separated

Address: _____ Apt: _____ City: _____ St.: _____ Zip: _____

Primary Phone: _____ Work: _____ Alternative: _____

ODL/State ID: _____ Employer: _____

Address: _____ City: _____ St.: _____ Zip: _____

Insurance Co. Name: _____ Policy/Group #: _____ St. Program ID #: _____

## PLEASE LIST TWO (2) PERSONAL REFERENCES (NOT WITH THE SAME ADDRESS)

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

### PLEASE THOROUGHLY READ BEFORE SIGNING:

I HAVE FILLED OUT THIS QUESTIONNAIRE ACCURATELY; I HAVE INFORMED YOU OF ALL MEDICAL PROBLEMS AND ALLERGIES OF WHICH I AM AWARE. I UNDERSTAND THAT ALL CROWNS, BRIDGES, DENTURES & PARTIAL DENTURES are custom work and the entire charge is incurred once the procedure has begun. I also understand that any remake of these procedures due to my failure to have them completed in the normal length of time may result in additional charges. I further realize the financial arrangements based on insurance are estimates based on normal ethical dental practices and available information concerning my insurance coverage and that I am ultimately responsible for all charges. **I also agree to keep all of my appointments and will give 24 hour notice for any cancellations**. I hereby authorize all insurance on third party payers to make payments directly to the dentist for services rendered. **IF A CHECK IS SENT TO ME DIRECTLY FROM THE INSURANCE COMPANY, I AGREE TO SUBMIT THE CHECK TO YOUR OFFICE WITHIN FIVE (5) BUSINESS DAYS.**

**PATIENT OR RESPONSIBLE PARTY SIGNATURE:** _____ **DATE:** _____

Name:_____ DOB: _____

Previous dentist:_____ Date of last exam: _____ Last cleaning:_____

Why are you here today? _____

# DENTAL HISTORY

| YES | NO | |
|---|---|---|
| ____ | ____ | Do you feel pain in any of your teeth? If so, where? _____ |
| ____ | ____ | Do your gums bleed while brushing or flossing? |
| ____ | ____ | Are your teeth sensitive to (circle) HOT COLD SWEET LIQUIDS FOOD BITING |
| ____ | ____ | Do you grind or clench your teeth? Pain in your jaw or frequent headaches? |
| ____ | ____ | Do you have any sores or lumps in your mouth that you are concerned about? |
| ____ | ____ | Do you have any broken teeth or fillings? (circle) UR UL LL LR |
| ____ | ____ | Have you had prolonged bleeding following an extraction? Have you had a dry socket? |
| ____ | ____ | Have you had a bad dental experience? If yes, please explain: _____ |

**HOW DID YOU HEAR ABOUT US?** _____

# MEDICAL HISTORY

Physician Name: _____ Phone: _____ Date of last visit:_____

| YES | NO | |
|---|---|---|
| ____ | ____ | Have you been hospitalized in the last 5 years? Reason?_____ |
| ____ | ____ | Have you been asked to take antibiotics before a dental appointment? |
| ____ | ____ | Do you have any **ALLERGIES** to any **MEDICATIONS**? (circle) PENICILLIN CODEINE VICODIN TETRACYCLINE E-MYCIN ASPIRIN OTHER: _____ |

Are you taking any **MEDICATION**? _____

# GENERAL CONDITIONS

| YES | NO | |
|---|---|---|
| ____ | ____ | Arthritis / Rheumatism |
| ____ | ____ | Artificial Joint / Pin |
| ____ | ____ | Cancer / Tumor |
| ____ | ____ | Chemo / Radiation |
| ____ | ____ | Diabetes |
| ____ | ____ | Epilepsy or seizures |
| ____ | ____ | Fainting or Dizzy spells |
| ____ | ____ | Glaucoma |
| ____ | ____ | Hepatitis A / B / C |
| ____ | ____ | HIV or AIDS |
| ____ | ____ | Kidney disease |
| ____ | ____ | Liver disease |
| ____ | ____ | Neurological disorder |
| ____ | ____ | Psychological problem |
| ____ | ____ | Nervous / Anxious |
| ____ | ____ | Respiratory problems |

| YES | NO | |
|---|---|---|
| ____ | ____ | Asthma |
| ____ | ____ | Allergies or hives |
| ____ | ____ | Sinus trouble |
| ____ | ____ | Steroid use |
| ____ | ____ | Stroke |
| ____ | ____ | Thyroid disease |
| ____ | ____ | Tuberculosis |
| ____ | ____ | Ulcers / Stomach problems |
| ____ | ____ | Diet / Special restriction |
| ____ | ____ | Latex sensitive |

**HAVE YOU EVER USED:**

| | | |
|---|---|---|
| ____ | ____ | Alcohol |
| ____ | ____ | IV drugs |
| ____ | ____ | Tobacco |
| ____ | ____ | Other drugs? |

| YES | NO | |
|---|---|---|
| | | **BLOOD** |
| ____ | ____ | Abnormal bleeding |
| ____ | ____ | Anemia |
| ____ | ____ | Blood transfusion |
| ____ | ____ | Leukemia |
| ____ | ____ | Bruise easily |
| | | **HEART PROBLEMS** |
| ____ | ____ | Heart murmur |
| ____ | ____ | Rheumatic fever |
| ____ | ____ | Angina / chest pain |
| ____ | ____ | Artificial valve / Shunt |
| ____ | ____ | Heart attack |
| ____ | ____ | Heart disease |
| ____ | ____ | High blood pressure |
| ____ | ____ | Low blood pressure |
| ____ | ____ | Pacemaker |

For women only: Do you suspect that you are PREGNANT? YES / NO #months?_____ Birth control pills? YES / NO

Is there anything else we should know about your health?_____

Emergency Contact (Name/Number): _____ Relationship to patient:_____

Patient / Responsible party signature:_____ Date: _____

## General Dental Treatment Consent and Information Form

It is the belief of this office that you should be informed about the treatment (therapy) we may recommend, and that you should give your consent before starting that treatment. The purpose of this form is to tell of the risks that may occur in dental treatment, and have your consent in writing.

### 1. Health Information

I agree to disclose all previous illness and medical history. Undisclosed medical information current medications, allergies, or illnesses may compromise my dental treatment.

### 2. Drugs, Latex and Medications

I understand that latex gloves, antibiotics, local anesthetics, and other medications can cause allergic reactions, even life threatening reactions. Also, some antibiotics can interfere with birth control pills. Epinephrine in local anesthetics can cause temporary increase in heart rate, and in rare cases may be dangerous.

### 3. Risks of Dental Procedures

Included, but not limited to, are complications resulting from the use of dental instruments, drugs, medicines analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheek and teeth, thrombophlebitis (inflammation to a vein) reaction to injections, loosening of the teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruise, delayed healing, sinus complications, and further surgery. Medications and drugs may cause drowsiness, lack of awareness, and coordination (which can be enhanced by the use of alcohol or other drugs), Thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours, or until recovered from their effects.

### 4. Fillings, Crown, and Unanticipated Root Canals

Some teeth may need a root canal even after a simple filling. Fillings and crowns are the most conservative treatment for diseased teeth, a percentage of these teeth end up needing a root canal after the filling or the crown is done.

### 5. Root Canals can Fail

Root canals have a high success rate but they can fail and may require additional or specialized treatment. A file can separate in the canal, or infections and abscess can recur, fractures and perforation of the canal can also be an issue. Some canals are calcified after root canals and can't be filled to the end of the root. In some cases the tooth may end up needing pulled or a specialist might be recommended to finish the treatment.

**6. Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings**

All these dental procedures are esthetically pleasing, however they may chip or break at some point in the future. The patient is responsible for repairs or remakes after 3 years for porcelain crowns and veneers. Once a crown, veneer or filling has been done the color cannot be changed.

**7. Gum Treatment and Requesting just a cleaning**

When regular cleanings are missed, or daily hygiene is improperly done, periodontal disease can result. This is destruction of the bone that supports teeth. I understand if I have periodontal disease, I will need more that a regular cleaning. Flossing daily is an integral part of good daily care. Smoking and poor oral hygiene will directly contribute to gum disease. I understand that a regular cleaning is not appropriate treatment for gum disease. I agree that if I need more intensive gum treatment, I will not insist that I simply get a regular cleaning. I understand that if my gum disease is too advanced I may be referred to a specialist.

**8. Extractions and surgery**

I understand that all dental extractions or dental surgeries carry risks. Some of those risks are infection, numbness (that can be temporary or permanent), severe pain and swelling.

**9. Fee for additional or Specialty Care**

I understand that I may require treatment beyond what was planned, such as when a tooth is crowned it might need a root canal. Also, I may be referred to a specialist for additional care. I agree to be financially responsible for the additional or specialty care.

**10. Change in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make any and all changes, additions, and/or deletions as the Dentist deems necessary. I hereby request and authorize the dentist and his staff to perform dental work on me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues and the risks involved, as well as the possible alternative methods for treatment that have been fully explained to me. I also authorize the operating dentist and assistants to perform any other procedure which they may deem necessary, or desirable in attempting to improve my condition, or treat unhealthy or unforeseen conditions that may be encountered during treatment.

**11. Dental Assistants**

Some of our Dental Assistants have extra certification to do sealants and place fillings. They are overseen by the dentists that have experience. **I hereby authorize the dental assistants to perform the restoration functions that each are certified to perform from placing permanent fillings and temps to taking impressions and other duties they are certified to perform.**

**12. Dental Treatment Can be Complicated**

Treatment can be complicated and while we try to anticipate any potential change to a treatment plan in advance, we may be able to realize some problems with teeth and the surrounding tissue until treatment has begun. If at this point additional treatment is needed we will inform you.

**13. Family Members in the Treatment Area**

One adult may accompany a minor to the treatment area if desired. However we do ask that no more than one family member is present. We cannot be responsible for managing children that are with adults undergoing treatment. Our services require full attention of our staff and doctors.

**14. Limitations of Insurance Coverage**

Insurances may not cover every procedure that we recommend. Some examples include, temporary dentures, removal of crowns or bridges, bleaching or cosmetic work. I understand what may be quotes as my portion (co-pay) is only an estimate. I agree to be financially responsible for what insurance does not cover or refuse to pay. We can try to help in guiding you regarding your insurance but at the end it is your insurance and your responsibility. We can't be held responsible if the insurance refuses to pay or they deny a claim.

**15. Unpaid Insurance Claims**

**Patient portions are due at the time of service.** All dental services rendered, whether or not covered by insurance are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you monthly letting you know the activity on your account. If you have paid the balance and your insurance company pays you will receive a prompt refund.

## 16. Consent

I understand that dentistry is not an exact science and that therefore we cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I am requesting and authorizing. I understand that no other dentist individual or corporation other that the treating dentist is responsible for my dental treatment. In order to receive treatment, I will agree that if there is any difference or disagreement between my attending dentist and myself, I will first present such differences or disagreement to my attending dentist and give him a chance to resolve the problem, if we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the grievance committee of my dental health plan, or the Dental Society and agree to accept their resolution, in lieu of pursuing remedies by way of litigation, in consideration of helping to keep cost of treatment of services as low as possible. I also understand that this agreement is binding on my heirs and all other family members. Alternatives and possible reactions have been explained to me in detail and clearly, including, but not limited to pain, bleeding, scarring, numbness, fractured jaw, and allergic reaction which on occasion can be life threatening.

Please understand we are here to serve you and help with your dental needs. If you have any questions or concerns let us know and we will do our best to take care of it. If you are dissatisfied with the services from the dentist or any of our dental staff, or billing issues please let us know and give us a chance to rectify the situation. Thank you for choosing our office.

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.**

_____ _____

Signature of Patient or Guardian Date

# Today's Dental

## Acknowledgment of Receipt of Notice of Privacy Practices

**I_____,**
**have received a copy of this office's Notice of Privacy Practices.**

**Name:** _____

**Signature:**_____

**Date:** _____

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# For Office Use Only

**We have attempted to obtain written acknowledgment of receipt of our Privacy Practices, but acknowledgment could not be obtained because:**

- **Individual refused to sign**
- **Communication barriers prohibited obtaining the acknowledgment**
- **An emergency situation prevented us from obtaining acknowledgment**
- **Other (please specify)**

**Today's Dental**
**570 SE Baseline St.**
**Hillsboro, OR 97123**

## Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

### Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect _____/_____/_____ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice

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### Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and health operations. For example:

**Treatment:** We may use and disclose your health information to a physician or other healthcare provider providing treatment for you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider's performance, conduction training programs, accreditation, certifications, licensing or credentialing activities.

### Your Authorization:

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

**To your Family and Friends:** We may disclose your health information to you, as described in the patients rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or to assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior use or disclosure of your health information, we will provide you with an opportunity to object relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

**Marketing Health Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health and safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail message, postcard, or letters).

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**Patient Rights**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format that you request unless we cannot practicably do so.
You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We reserve the right to charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associated disclosed your health information for a purpose, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14,2003.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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**Question and Complaints**

If you want more information about our privacy practices of have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use and disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with them upon request. We support your right to privacy and will not retaliate in anyway should you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office Manager: Anna Meisner
Today's Dental
570 SE Baseline St.
Hillsboro, OR 97123
(503) 844-0777 • (503) 648-5948
Fax: (503) 648-9603