

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME		LAST	FIRST	MI	DATE OF BIRTH	SEX	SSN(US) / SIN(CAN)
PREFER TO BE CALLED			HOME PHONE #			CELL PHONE #	
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	E-MAIL
MARITAL STATUS		PATIENT'S / GUARDIAN'S EMPLOYER				OCCUPATION	
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> UNDER AGE 18							
WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE #
SPOUSE'S NAME		LAST	FIRST	MI	SPOUSE'S EMPLOYER		OCCUPATION
SPOUSE'S WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE #
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE					WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?		

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME		RELATIONSHIP	
HOME PHONE #	WORK PHONE #	CELL PHONE #	

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via cell phone	<input type="checkbox"/>	<input type="checkbox"/>
Contact me at work	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via e-mail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my home voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my cell phone voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my work voicemail	<input type="checkbox"/>	<input type="checkbox"/>

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE		INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
<input type="checkbox"/> YES <input type="checkbox"/> NO				
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)
	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT			
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS	
SECONDARY COVERAGE		INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
<input type="checkbox"/> YES <input type="checkbox"/> NO				
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)
	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT			
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers	<input type="checkbox"/>	<input type="checkbox"/>	1.
Insurance Companies	<input type="checkbox"/>	<input type="checkbox"/>	2.

CONFIRMATIONS



DO YOU PREFER A CONFIRMATION CALL

- No, it is unnecessary Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE
If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.	
SIGNATURE - GUARANTOR OF PATIENT	DATE

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY **YES NO**

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____

GUM AND BONE **YES NO**

7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

TOOTH STRUCTURE **YES NO**

14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT **YES NO**

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench or grind your teeth together in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS **YES NO**

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



19157 Willamette Drive, West Linn, Oregon 97068
503-635-4493

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected

Signed this _____ day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to patient _____



FINANCIAL POLICY

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are always available to answer your questions or assist you in any way we can.

We happily accept cash, personal checks, or credit cards (Visa, MasterCard, Amex and Discover).

We also offer monthly payment plans through Care Credit. No interest plans up to 12 months and extended, low interest, payment plans up to 60 months are available.

There will be a \$50 minimum charge for any broken appointment or appointment not cancelled or rescheduled with at least a **24 HOUR NOTICE**. The length of time scheduled for your appointment will determine the charge. The fee will be calculated based on a \$100 charge for each hour reserved for you, the patient.

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy without letting your insurance company dictate your care. We cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance pays. In this instance we will bill you for the remaining amount due.

I, _____, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all the charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 90 days will become my responsibility to pay at that time. I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claims, (3) the use of my dental records by my dentist in any professional manner that he determines.

Patient (or responsible party) Signature: _____ Date: _____