



Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ SS #: _____ Driver's license #: _____ State: _____

E-mail: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Daytime sleepiness? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good Health? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sweets? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care? _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw symptoms or headaches upon awaking in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating or depressing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker? _____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>

Blood Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>

Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>

Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>

Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		

Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
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Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
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Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
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Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
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Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
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Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>
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Premedications required by physician _____	<input type="checkbox"/>	<input type="checkbox"/>
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Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine") _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen _____	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals _____	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Pulse Rate: _____

Respiratory Rate: _____

Blood Pressure: _____ Date: _____

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>

Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
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Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		

Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		

Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
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Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
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HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
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Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
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Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
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History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
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Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
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History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
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Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin) _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers _____	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin _____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies _____	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Women	Yes	No
Are you taking contraceptives or other hormones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Dentist Initial: _____

Hygienist Initial: _____

Patient/Parent Signature: _____

Date: _____



INFORMATION ABOUT YOUR DENTAL INVESTMENT

We feel strongly that our patients deserve the best possible care we can provide. In an effort to provide and maintain that high quality care, we would like to share some information with you about **financing your dental care**. Our hope is that by providing you the following information we can prevent misunderstandings and that you will be comfortable discussing financial and insurance matters with us. We urge you to consult with us if you have any questions regarding our fees and/or services.

1. At each visit we ask that you make full payment unless other arrangements have been made. If you have dental insurance, we ask that you pay that portion which your insurance **does not pay**. *There will be a \$10 monthly statement fee applied to any accounts where co-pays are not paid in full at the time of treatment after the first 30 days.*
2. **Cash, Personal Check, Visa, MasterCard, American Express, Citihealth, & Care Credit** may be used for payment of your account. *Please see our financial coordinator for details on 0% third-party financing.*
3. A 5% **cash courtesy** adjustment will be given to patients without insurance if you pay 100% of your treatment on the date of service with cash or check.
4. Outstanding account balances are due in full within 30 days of service unless other arrangements have been made. A finance charge of 1.5% per month (18% per year) will be assessed to balances over 30 days past due regardless of pending insurance coverage. We encourage you to check with your insurance company if they have not made payment within 30 days of your treatment date.
5. As a courtesy to you we will help you process all your insurance claims. *Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated.* Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
6. The parent that brings a minor in for treatment and signs below as guarantor is responsible for payment of services rendered. Our office does not recognize agreements between parents accepting or denying financial responsibility for dental fees.
7. **Delinquent accounts** will be referred to collection at the discretion of the office manager. There will be a \$100.00 collection processing charge for those accounts referred to collection. There is a \$25.00 charge for checks returned for non-sufficient funds.

8. Except in emergency situations, you can expect us to be on time for you, and we will appreciate the same courtesy.
9. *Your appointment time is tailored for you. If the need arises to reschedule your appointment, please provide us at least a 24 hour notice.*
10. Without adequate notification, we will not be able to give your reserved time to another patient in need of dental care. There is a \$50.00 broken appointment fee for every hour of the scheduled appointment. This fee covers the room preparation charge and the idle time of the Doctor, hygienist and dental assistant who were on duty to provide your personalized care.
11. If your schedule does not permit you to plan in advance, we might suggest placing you on our list of patients to call on short notice basis.

If you have any questions, we would appreciate your prompt inquiry.

I understand the terms and conditions as stated above and accept full financial responsibility for any treatment rendered.

Print name: _____

Signed: _____

Date: _____



HIPAA Privacy Policy

NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The purpose of this Notice is to provide you with information regarding our privacy practices, including the ways in which we may use or disclose your health information. The Notice also describes your rights and our obligations concerning such uses and disclosures.

Uses and Disclosures.

Northwest Dental Arts is committed to maintain the privacy and confidentiality of your health information.

Treatment.

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, laboratory results, surgery information, specialized testing, co-management information, etc. will be available in your medical record to all health professionals who may provide treatment now or in the future.

Payment.

Your health information may be used to seek payment from your health plan or other sources of payment, including finance companies that you may use for services. For example, your health plan may request dates of service, services rendered, and diagnosis.

Health care operations.

Your health information may be used for evaluation of the day-to-day operations of Northwest Dental Arts. For example, your procedure or services may be used for financial reporting.

Family and friends.

With your approval and using our professional judgment, your health information may be disclosed to designated family, friends, and others who are directly involved in your care or the payment of your care. If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval.

Law enforcement.

Your health information may be disclosed to law enforcement officials, without your permission, to support government audits and inspections and to comply with government reporting.

Public health reporting.

Your health information may be disclosed to public health officials as required by law. For example, we are required to report certain infectious diseases to the state's public health department.

Worker's compensation.

Your health information may be disclosed, for purposes of payment, if there is a work-related illness or injury.

Other uses and disclosures require your authorization.

Disclosure of your health information or its use for any purpose other than those listed above requires your written authorization. A written revocation of the authorization can be made at any time. This revocation will not affect the previous release of information.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to remind you of upcoming appointments.

Newsletters.

Your health information will be used by our staff to send you a newsletter. You may call our office if you do not wish to receive the newsletter.

Your Rights.

Restrictions on Use and Disclosure of Individual Health Information. You have the right to request restrictions on some of our uses and disclosures of your health information. These restrictions must be made in writing and signed by you. This office is not required to abide by your restrictions. We retain the right to terminate a restriction if we believe such termination is appropriate. You have the right to terminate, in writing or orally, any restriction by sending such termination notice to the Compliance/Privacy Officer at 4734 River Rd. N. Keizer, Oregon 97303

Access to Individual Health Information.

You have the right to inspect and copy your health information maintained by this office. All requests for access must be made in writing and signed by you or your representative. There may be a nominal fee per page and for postage, if a mailed copy is requested. You may obtain a request for access form from the Compliance/Privacy Officer at 4734 River Rd. N. Keizer, Oregon, 97303

Amendments to Individual Health Information.

You have the right to request in writing that your health information maintained by this office be amended. In certain cases, we may deny your request for the amendment. All amendment requests must be made in writing and signed by you or your representative, and must state the reason for the amendment. You may obtain an amendment request form from the Compliance/Privacy Officer at 4734 River Rd. N. Keizer, Oregon, 97303. If we deny your request, you may submit a statement of disagreement to us. Please contact the Compliance/Privacy Officer for questions about amendments to your health information.

Accounting for Disclosures of Individual Health Information.

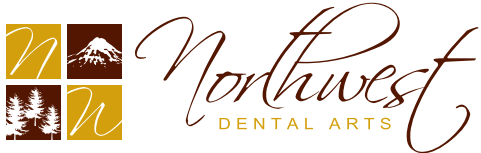
You have the right to receive an accounting of certain disclosures made by us of your health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Compliance/Privacy Officer at 4734 River Rd. N. Keizer, Oregon, 97303. There may be a nominal fee for each accounting you request. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Complaints.

If you believe your privacy rights have been violated, you may file a complaint with the Compliance/Privacy Officer at 4734 River Rd. N. Keizer, Oregon, 97303. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. in writing. There will be no retaliation for filing a complaint.

Additional Information.

If you have any questions or need additional assistance regarding this Notice, you may contact the Compliance/Privacy Officer at 4734 River Rd. N. Keizer, Oregon, 97303 or by phone (503)463-4663.



**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM**

Name: _____

Date: _____

CHECK AND SIGN OPTION ONE OR OPTION TWO BELOW, PLEASE.

OPTION ONE:

_____ I have received a copy of Practice's Notice of Privacy Practices.

Signature: _____

OPTION TWO:

_____ I was offered a copy of the Practice's Notice of Privacy Practices, but did not want it.

Signature: _____

For Office Use Only:

_____ A good faith effort was made to provide a copy of the Practice's Notice of Privacy Practices to this patient and to obtain his/her acknowledgement of the same. The patient _____ accepted _____ declined the Notice and refused to sign this acknowledgement for the following reason:

Practice Representative: _____

Signature: _____ Date: _____