**Registration-Dental History-Authorization & Rele

Phone

Birthdate **Entry Date: 03/30/2022**

Patient/Responsible Party

Patient Information

Name (Last, First, Middle) _____ ☐ Female ☐ Male ☐ Other Birthdate _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Employed by _____ How Long? _____

Occupation _____ Social Security # _____

Referred by _____

Have you or any family members been treated in this office before?

List _____

Person responsible for bill (if not self)

Name of responsible party _____ Relation _____

Address _____ City _____ State _____ Zip _____ Soc. Sec. # _____

Employer / Address _____ How Long? _____

Home # _____ Work # _____

In case of emergency, person to contact other than parent / spouse

Name _____ Relation _____

Address _____ Phone # _____

Payment: ☐ Cash ☐ Oregon Health Plan ☐ I wish to discuss the office payment policy ☐ Third Party

☐ Insurance ☐ Credit Card ☐ Care Credit Loan

*If you have provided us with your insurance card prior, you do not need to fill this portion out. Thank you!

**Registration-Dental History-Authorization & Rele

Birthdate Entry Date: 03/30/2022

Insurance

Primary Insurance Information

Policy holder name _____ Soc. Sec. # _____ Birthdate _____

Dental Insurance

Insurance Co. _____
Ins. Co. Address _____
City/State/Zip _____
Ins. Co. Phone# _____
Group# _____ ID# _____

Medical Insurance

Insurance Co. _____
Ins. Co. Address _____
City/State/Zip _____
Ins. Co. Phone# _____
Group# _____ ID# _____

Secondary Insurance Information

Policy holder name _____ Soc. Sec. # _____ Birthdate _____

Dental Insurance

Insurance Co. _____
Ins. Co. Address _____
City/State/Zip _____
Ins. Co. Phone# _____
Group# _____ ID# _____

Medical Insurance

Insurance Co. _____
Ins. Co. Address _____
City/State/Zip _____
Ins. Co. Phone# _____
Group# _____ ID# _____

**Registration-Dental History-Authorization & Rele

Birthdate **Entry Date: 03/30/2022**

Dental History/Authorization/Release

Reason for this visit _____

When was your last dental visit? _____ What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist (name and location _____

Have you had a complete series of dental films (x-rays) taken / when / where _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Is your drinking fluoridated? _____

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids / foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids / foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw:		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐

	Yes	No
Do you bite your lips or cheeks frequently?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐
Does food tend to become caught between your teeth?	☐	☐
Have you every had periodontal treatment (gums)?	☐	☐
Ever worn a bite plate or other appliance?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

If you could change anything about your smile, what would you change? _____

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 than 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 of 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.

Signature of patient or parent/guardian if minor

x _____

_____

Signer's Full Name Date

**Medical History

Phone

Birthdate **Entry Date: 03/30/2022**

Medical History

I consider my health to be (please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physician's name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? ☐ Yes ☐ No
These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.)

Do you or have you ever taken any of the group of drugs collectively referred to as "biophosphnates"? ☐ Yes ☐ No
This group of drugs is commonly used for treating osteoporosis and/or for cancer treatments. Sample generic names such as: Fosamax (alendronate), Actonel (risedronate), etc.

Have you had any serious illnesses or operations? _____

If yes, please describe. _____

Have you ever had a blood transfusion? ☐ Yes Date _____ ☐ No

(Women)	Are you pregnant?	☐ Yes ☐ No	Nursing?	☐ Yes ☐ No
	Taking birth control pills?	☐ Yes ☐ No		

Do you have or have you had any of the following? (Please check all that apply

☐ Anemia	☐ Scarlet Fever	☐ Hepatitis	☐ Diabetes
☐ Artificial Joints	☐ Stroke	☐ Jaw Pain	☐ Glaucoma
☐ Blood Disease	☐ Tonsillitis	☐ Mitral Valve Prolapse	☐ Heart Problems
☐ Chemotherapy	☐ Venereal Disease/STD	☐ Respiratory Disease	☐ High Blood Pressure
☐ Cough, persistent	☐ Arthritis, Rheumatism	☐ Shortness of Breath	☐ Kidney Disease
☐ Epilepsy	☐ Asthma	☐ Swelling of Feet or Ankles	☐ Pacemaker
☐ Headaches	☐ Cancer	☐ Tuberculosis	☐ Rheumatic Fever
☐ Hemophilia	☐ Circulatory Problems	☐ Artificial Heart Valves	☐ Skin Rash
☐ HIV/AIDS	☐ Cough up blood	☐ Back Problems	☐ Thyroid Problems
☐ Liver Disease	☐ Fainting	☐ Chemical Dependency	☐ Ulcers
☐ Radiation Treatment	☐ Heart Murmur	☐ Cortisone Treatments	

Do you smoke or use tobacco? ☐ Yes ☐ No How often? _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____

Have you taken medication before your dental appointments? ☐ Yes ☐ No

Have you consumed alcohol withing the last 24 hours? ☐ Yes ☐ No

Do you use other drugs? ☐ Yes ☐ No How often? _____

Allergies to Medications

Select all that apply

☐ Aspirin	☐ Penicillin	☐ Latex
☐ Codeine	☐ Erythomycin	☐ Tetracycline

☐ Dental Anesthetics ☐ Jewelry or Metals ☐ Other _____

Patient or responsible party

X _____

_____

Signer's Full Name Date

Are you currently taking any medications? Please list them here:

**HIPAA Release Form

Phone

Birthdate **Entry Date: 03/15/2019**

HIPAA Release Form

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims inforamtion.

This information may be released to:

☐ Spouse _____

☐ Child/Children _____

_____

☐ Other _____

☐ Information is not to be released to anyone

*This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ☐ My home ☐ My work ☐ My cell number _____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ Other _____

The best time to reach me is (day) _____ between (time) _____

Signed

X _____

_____

Signer's Full Name Date

**HIPAA Acknowledgement

Phone

Birthdate **Entry Date: 05/19/2020**

Privacy Practices

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my right to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers for my health care services.
Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has that right to change the Notice of Practice Practices and that I may contact this office at the address above to obtain a curren 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 of health care operations and I undertsand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ Date _____

Signature

X _____ Date _____

Signer's Full Name

Dependent family members also covered by this acknowledgement:

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

Reason
- ◯ The patient refused to sign
- ◯ Emergency situations
- ◯ Communication barriers
- ◯ Other

Other reason _____

**Registration-General Consent

Phone

Birthdate **Entry Date: 03/30/2022**

Consent

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the Doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records.

I certify that the above insurance information, if applicable, is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by Doctor Edward Ward, and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. I agree that credit bureau reports may be obtained, where appropriate.

Signature of patient, parent, guardian or responsible party

x _____

_____

Signer's Full Name Date

Relationship to Patient _____