WILSONVILLE
DENTAL CARE

Patient Information

Title _____ First Name _____ M.I. _____ Last Name _____ Prefer to be called _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Social Security # _____ Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you hear about our office? _____ Other family members seen by us: _____

Emergency Contact

First Name _____ Last Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____

Responsible Party / Patient

Who will be financial responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other: _____

If self, please continue to the next section. For anyone else, please complete the following information:

Title _____ First Name _____ M.I. _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Social Security # _____ Driver's License # _____ Employer _____

Primary Dental Insurance ☐ Does not apply

Insurance Company Name: _____ ID # _____ Group # _____

Company Address _____ City _____ State _____ Zip Code _____

Company Phone Number _____ Are you the main subscriber? ☐ Yes ☐ No

Subscribers Name _____ Date of Birth _____ Relationship to Patient _____

Secondary Dental Insurance ☐ Does not apply

Insurance Company Name: _____ ID # _____ Group # _____

Company Address _____ City _____ State _____ Zip Code _____

Company Phone Number _____ Are you the main subscriber? ☐ Yes ☐ No

Subscribers Name _____ Date of Birth _____ Relationship to Patient _____

Dental History

When was the last time you were seen by a dentist? _____ When was your last dental cleaning? _____

What is the name of your previous dental office? _____ Phone Number _____

Reason for today's visit _____ Are you in pain? ☐ Yes ☐ No For how long? _____

Please rate your current dental health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How do you feel about your smile? Is there anything you'd like to change? _____

Are you fearful of dental treatment? ☐ Yes ☐ No Please explain: _____

Have you ever had trouble getting numb or had reactions to local anesthetic? ☐ Yes ☐ No

Please describe: _____

Do your gums bleed?	Yes	No
Is your mouth dry?	Yes	No
Teeth sensitive to heat, cold, sweets, brushing, or flossing?	Yes	No
Have you noticed any bad tastes or bad breath?	Yes	No
Have you ever had periodontal (gum) treatment?	Yes	No
Have you ever had orthodontic (braces) treatment?	Yes	No
Have you had any problems associated with previous dental treatments?	Yes	No
Do you have any ear aches or neck pains?	Yes	No
Do you have any clicking, popping, or discomfort in the jaw?	Yes	No
Have you noticed any loose or shifting teeth?	Yes	No
Do you clench your teeth or grind?	Yes	No
Have you had headaches on a regular basis in the morning, evening, or after eating?	Yes	No
Have you had your bite adjusted?	Yes	No
Do you have sores or ulcers in your mouth?	Yes	No
Do you wear dentures or partials?	Yes	No
Have you ever had a serious injury to your head or mouth?	Yes	No
Do you use a CPAP or snore guard?	Yes	No

Health History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical exam _____ Are you now under the care of a physician? ☐ Yes ☐ No

Physician's Name _____ Physician's Phone Number _____

For women: ☐ Are you pregnant? ☐ Yes ☐ No How many weeks? _____

Taking birth control pills or hormone replacement? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Have you had a serious illness, operation, or been hospitalized in the last five years? ☐ Yes ☐ No

What was your illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medications? ☐ Yes ☐ No

Please list any medications (prescription or over the counter) you are taking: _____

Do you require antibiotics prior to receiving dental care? ☐ Yes ☐ No

Do you take or have you taken Phen-Fen or Redux? ☐ Yes ☐ No Are you on a special diet? ☐ Yes ☐ No

Are you taking or scheduled to begin taking either of the medication's alendronate (Fosamax®) or risedronate (Actonel®) for Osteoporosis or Paget's disease? ☐ Yes ☐ No

Have you ever or are you presently being treated with the intravenous bisphospohonates (Aredia® or Zometa®)? ☐ Yes ☐ No

Do you use tobacco (smoking, chew, snuff, etc.)? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No Do you use controlled substances (drugs)? ☐ Yes ☐ No

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetics	Yes	No	Details: _____
Aspirin	Yes	No	Details: _____
Penicillin or other antibiotics	Yes	No	Details: _____
Barbiturates, sedatives, or sleeping pills	Yes	No	Details: _____
Sulfa drugs	Yes	No	Details: _____
Codeine or other narcotics	Yes	No	Details: _____
Metals	Yes	No	Details: _____
Latex (rubber)	Yes	No	Details: _____

Other _____

Medical Conditions

AIDS/HIV Positive	Yes	No	Excessive Bleeding	Yes	No	Mitral Valve Prolapse	Yes	No
Alzheimer's Disease	Yes	No	Excessive Thirst	Yes	No	Pain in Jaw Joints	Yes	No
Anaphylaxia	Yes	No	Fainting Spells/Dizziness	Yes	No	Parathyroid Disease	Yes	No
Anemia	Yes	No	Frequent Cough	Yes	No	Psychiatric Care	Yes	No
Angina	Yes	No	Frequent Diarrhea	Yes	No	Radiation Treatment	Yes	No
Arthritis/Gout	Yes	No	Frequent Headaches	Yes	No	Recent Weight Loss	Yes	No
Artificial Heart Valve	Yes	No	Genital Herpes	Yes	No	Renal Disease	Yes	No
Artifical Joint	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Hay Fever	Yes	No	Rheumatism	Yes	No
Blood Disease	Yes	No	Heart Attack/Fever	Yes	No	Scarlet Fever	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No	Shingles	Yes	No
Breathing Problems	Yes	No	Heart Pace Maker	Yes	No	Sickle Cell Disease	Yes	No
Bruise Easily	Yes	No	Heart Trouble/Disease	Yes	No	Sinus Trouble	Yes	No
Cancer	Yes	No	Hemophilia	Yes	No	Spina Bifida	Yes	No
Chemotherapy	Yes	No	Hepatitis A	Yes	No	Stomach/Intestinal Disease	Yes	No
Chest Pains	Yes	No	Hepatitis B or C	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	Herpes	Yes	No	Swelling Limbs	Yes	No
Congenital Heart Disease	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Convulsions	Yes	No	Hives/Rash	Yes	No	Tonsilitis	Yes	No
Cortisone Medication	Yes	No	Hypoglycemia	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Irregular Heartbeat	Yes	No	Tumors/Growths	Yes	No
Drug Addiction	Yes	No	Kidney Problems	Yes	No	Ulcers	Yes	No
Easily Winded	Yes	No	Leukemia	Yes	No	Venereal Disease	Yes	No
Emphysema	Yes	No	Low Blood Pressure	Yes	No	Yellow Jaundice	Yes	No
Epilepsy or Seizures	Yes	No	Lung Disease	Yes	No			

Are there any other conditions, disease, or problem not listed we should know about? _____

Confirmation

I certify that the information give on this form is accurate. I understand the importance of a truthful health history and that my dentist and their staff will rely on this information for treating me. I will not hold my dentist, or any other staff member, responsible for any action they take or do not take because of the errors or omissions that I may have made in the completion of this form.

Printed Name _____ Signature _____ Date _____

OFFICE FINANCIAL POLICY

30045 SW Parkway Avenue
Wilsonville, OR 97070

In our continued commitment to provide the highest quality of dental care available to all of our patients, and to have those services comfortably affordable, we are pleased to offer you these options for payment:

- Care Credit
- All major credit cards
- Cash or check

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

Patients are responsible for all charges resulting from care at our office. As a courtesy to you, we will submit charges resulting from your visit to your insurance company with our assignment of benefits so that payment can be made on your behalf. We will also be happy to bill more than one insurance company for you. Treatment estimates are not a guarantee of payment by your insurance company. We are not responsible for incorrect information supplied to us by your insurance carrier. It is your responsibility to confirm your dental benefits with your insurance carrier. Should insurance companies delay payment, you will need to participate in expediting payment. As patients, please be aware that there are many insurance companies and different programs within those companies. Our staff cannot be expected to be "experts" on what is covered and what is not covered.

I agree that I am fully responsible for the total payment of all procedures performed in this office. This includes any treatment that is not a benefit of any insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within (60) days of the date of service, regardless of whether or not my insurance benefits have been received. If for any reason, the estimated amount is not paid by your insurance company, it becomes your obligation. One and once half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

Cancellation/No Show Policy: I understand that I will be billed $40 per appointment cancellation if I cancel with less than 48 hours' notice or do not arrive for my scheduled appointment.

Authorization to Perform Dental Treatment: I hereby authorize the team at Wilsonville Dental Care to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also authorize the doctor to prescribe any and all forms of medication and perform any therapy that may be indicated and agreed upon. I further authorize the release of any information, including the diagnosis and records of any treatments or examinations rendered, to my insurance company or consulting professionals.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

I have read the above conditions of treatment and agree to their content.

Patient Name (Printed)	Date
Signature (Responsible Party)	Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
(Please print name)

_____
(Signature)

_____
(Date)

For Office Use Only

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: _____

_____	_____	_____
Printed Name of Team Member	Signature of Team Member	Date