Mintie Family Dentistry
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511 SW 10th Ave, Suite 804 • Portland, OR 97205 (503)243-2505

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID#:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID#:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

PLEASE CHECK ALL THAT APPLY FROM THE FOLLOWING

PERSONAL HISTORY:

☐ 1. Are you fearful of dental treatment? If so, how much 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:

☐ 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 lsot bone around your teeth?

☐ 9. Have you ever noticed an unpleasant tast 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 in 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:

☐ 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 your teeth?

BITE AND JAW JOINT:

- ☐ 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 betweeen 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 making your gums 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:

- ☐ 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?

If any of the checked boxes need further explanation, please describe:

Financial Policy Acknowledgement

We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence. If you have insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy. For the convenience of our patients we offer the following methods of payment of fees.

. Payment in full by cash, bank card or alternate financing of each appointment as service is rendered.
o Bank charge cards - Visa, MasterCard, Discover, American Express, CareCredit and Debit cards are accepted.
o Alternate financing (payment plans) must be arranged before treatment is rendered.

. For insurance patients, we will accept payment directly from the insurance company only for that percentage the company will cover and do require that the deductible and non-covered fees be paid at each visit.
. We may charge a fee of up to $100 per hour for any missed or canceled appointment within 24 HOURS of appointment. After two appointments have been missed consecutively, we will require a deposit of $100 to hold your next appointment. Our time must be used as efficiently as possible to keep our expenses at a minimum and our fees within reasonable limits.

Our office staff understands insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract. It is important that you realize, however. .

. Your insurance benefit is a contract between you, your employer, and the insurance company. We are not a party to your contract. This office files your insurance claim as a courtesy to you.
. Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your carrier.
. Not all services are a covered benefit in all contracts.

. You (not the insurance company) are responsible to us for all fees for services rendered to you..
. If your insurance has not paid within 45 days of submitted charges, please call our office so we can verify your insurance information and review the details of your account with you. After 60 days, you are responsible to begin payments while we continue to work with your insurance together.
. Upon request, a pre-determined estimate of benefits can be given to you. We remind you these are estimates and actual benefits may vary from the estimates provided.
. We will gladly discuss your proposed treatment and answer any questions you might have as to the involvement of your benefit program in receiving this care. We appreciate the opportunity to serve you.

THERE IS NO INTEREST OR FINANCE CHARGE ON CURRENT ACCOUNTS. AFTER 90 DAYS, ALL ACCOUNTS ARE SUBJECT TO A FINANCE CHARGE OF 1% OF THE UNPAID BALANCE, WHICH IS AN ANNUAL PERCENTAGE RATE OF 12% (or a minimum charge of $1.00)

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature and acknowledge that you are financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. You hereby authorize the doctor to release information necessary to secure payment.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: ____/____/_____