

HEALTH HISTORY & REGISTRATION

PATIENT NAME (Last) _____ (First) _____ (MI) _____ Preferred Name _____
BIRTHDATE _____ AGE _____ GENDER (M / F) MARITAL STATUS _____ SS# _____
RESIDENCE Street _____ City _____ State _____ Zip _____
MAILING ADDRESS Street _____ City _____ State _____ Zip _____
PHONE #'S Home _____ Work _____ Ext _____ Cell _____
E-MAIL _____ EMPLOYER _____ DRIVER'S LICENSE # _____

Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY/SPOUSE INFORMATION (IF DIFFERENT FROM PATIENT)

PATIENT NAME (Last) _____ (First) _____ MI _____ Preferred Name _____
BIRTHDATE _____ AGE _____ GENDER (M / F) MARITAL STATUS _____ SS# _____
RESIDENCE Street _____ City _____ State _____ Zip _____
MAILING ADDRESS Street _____ City _____ State _____ Zip _____
PHONE #'S Home _____ Work _____ Ext _____ Cell _____
E-MAIL _____ EMPLOYER _____ DRIVER'S LICENSE # _____

EMERGENCY INFORMATION (Relative not living with you)

NAME _____ RELATIONSHIP _____
ADDRESS _____ CITY/STATE _____
PHONE #'S Home _____ Work _____ Ext. _____ Cell _____

PRIMARY INSURANCE

INSURANCE COMPANY NAME _____ PHONE # _____
SUBSCRIBERS NAME _____ BIRTHDATE _____
POLICY OR SS# _____ GROUP # _____ GROUP NAME _____

SECONDARY INSURANCE

INSURANCE COMPANY NAME _____ PHONE # _____
SUBSCRIBERS NAME _____ BIRTHDATE _____
POLICY OR SS# _____ GROUP # _____ GROUP NAME _____

HIPAA PRIVACY POLICIES

We are required by law to maintain the privacy of, and provide individuals with, notice of our legal duties and privacy practices with respect to protected health information. By signing below you acknowledge that you have been offered a copy of the federal HIPAA privacy practices. _____ **(Initials)**

Also, for accounting/bookkeeping purposes, I agree to allow Oak Park Dental to list information regarding all family members' dental services or account information on one statement. _____ **(Initials)**

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated, once fully explained.

Signed _____

Date _____

MEDICAL HISTORY AND DENTAL HISTORY

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your dental health. Thank you for taking the time to completely fill out this information.

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?		
Are you under a PHYSICIAN'S CARE now?		
If Yes, please explain:		
PHYSICIAN NAME	PHONE (include area code)	
DATE of last PHYSICAL EXAM		
Are you PREGNANT?		
Are you having PROBLEMS now?		
Are your APPREHENSIVE about dental treatment? Please describe.		
Are you UNHAPPY with the appearance of your teeth? Please describe.		

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.			Fainting			Psychiatric care		
Anaphylaxis			Food allergies			Rapid weight gain/loss		
Anemia			Glaucoma			Radiation treatment		
Arthritis (Rheumatism)			Headaches			Respiratory disease		
Artificial heart valves			Heart murmur			Rheumatic/scarlet fever		
Artificial joints			Heart problems (please describe)			Shingles		
Asthma						Shortness of breath		
Atopic (Allergy Prone)			Hemophilia (Abnormal bleeding)			Skin rash		
Back problems			Herpes			Sleep Apnea		
Blood disease			Hepatitis			Spina Bifida		
Cancer			High blood pressure			Stroke		
Chemical dependency			Jaw pain			Surgical implant		
Chemotherapy			Kidney disease or malfunction			Swelling of feet or ankles		
Circulatory problems			Liver disease			Thyroid disease/malfunction		
Cortisone treatments			Material allergies (Latex, wool, metal, chemicals)			Tobacco habit		
Cough (Persistent)						Tonsillitis		
Cough up blood			Mitral valve prolapse			Tuberculosis		
Diabetes			Nervous problems			Ulcer/Colitis		
Epilepsy			Pacemaker/heart surgery			Venereal disease		

Medications: What medications, including vitamins, supplements, or over-the-counter medications, are you currently taking?

Have you ever taken any of these medications for Osteoporosis? (please circle) Fosamax, Actonel, Boniva, Aredia, Zometa

Have you ever taken any cancer drugs? Yes No If yes, _____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.) Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances? If yes, please list.

Patient Name _____ **Date** _____

Signature _____

FINANCIAL AGREEMENT

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

All accounts are due and payable at the time of service.

Payment Plans: We offer up to 12 months interest free financing with Care Credit or Wells Fargo on approved credit

Discounts:

Cash or Check

- 5% Pre-Payment Discount (if paid at least one week prior to appointment)
- 5% Senior Discount (For ages 62 and over)

-OR-

Credit Card

- 3% Pre-payment discount (if paid at least one week prior to appointment)

Patients with Insurance: You are responsible for the estimated non-covered portion, procedures and/or deductibles at the time of service. **If for any reason insurance does not pay what is estimated, the leftover balance is your responsibility.** By signing below, you authorize your insurance company to assign benefits to this office so that we may credit them towards your account.

Parents not accompanying their child to an appointment must make prior arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

There is an 18% annual interest rate for any unpaid balance after 60 days and a \$30.00 returned check fee.

Release or copies of records can result in a \$50 fee.

Because instruments, chairs and personnel are reserved exclusively for your appointment, there is a **\$50 charge for changed or broken appointments with less than a 24 hour notice.**

I, _____, agree to these financial terms.

Signature _____ Date _____

Oak Park Dental

3380 Astoria Way NE
Salem, OR 97305
Phone# 503-588-7800
Fax # 503-391-0762

CONSENT TO SHARE DENTAL INFORMATION

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE OAK PARK DENTAL TO SHARE: (Please check all that may apply)

- Treatment plan information (such as treatment needs and details about oral health condition)
- Medications I am taking
- Billing Information
- Appointment Dates/Times and reasons for the visits

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

- I do **not** want Oak Park to share any of my health/dental information with anyone.

I understand that I may cancel this consent at any time, but that cancelling it will not affect any information that has already been released.

- I consent Oak Park Dental to leave detailed messages regarding my appointments, treatment needs and medications at the phone number/s listed below.

Phone # _____ Phone # _____

Patient Signature: _____ Date: _____