Wilshire Dental Neil J Gehred D.D.S. 503-284-6469

Patient Information Date_____

Full Name_____Prefer_____
Address_____
City, State, Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Birth Date_____ Soc Sec_____ Drivers Lic_____
E-mail_____

Sex: ____Male ____Female Marital Status: _____Married _____Single _____Other
Employment Status: _____Full Time _____ Part Time _____ Retired _____Other
Student Status: _____Full Time _____Part Time _____School
Person to contact in case of emergency_____Phone_____
How did you hear about us?_____
Responsible Party (if someone other than patient)
Full Name_____ Phone_____
Relationship to patient_____

Primary Insurance Information:

Name of Insured:_____ Insured Soc Sec:_____
Relationship to Insured:____Self____Spouse____Child____Other Insured Birth Date:_____
Employer:_____
Insurance Company:_____ Group Number:_____
Insurance Phone:_____ Policy Number:_____

I authorize my insurance company to pay Wilshire Dental all insurance benefits otherwise payable to me of services rendered. I authorize the use of this signature on all insurance submissions.
I authorize Wilshire Dental to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all services provided to me and/or my dependent(s), regardless of insurance payments.
I agree to pay all late and/or finance charges accrued on my account.
Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits and eligibility. You agree to pay any portion of the charges not covered by insurance.

Signature_____ Date _____

Confirmation and Cancellation Policy

- Our office will contact you 1-2 day before your appointment. Do you prefer call/email/text? _____
- You, the patient, will give our office **24 hours** notice if you need to move your appointment time or day.
- If we do not receive **24 hours** notice, a fee will be charged for **less than 24 hours notice or failed appointment** to offset the preparation and resetting time for your treatment room.
- Remember, each appointment is set aside **exclusively for you or your family members.** Our goal is to be thoroughly prepared for you. Thank you for your understanding.

Signature _____ Date _____

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs, which may be incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all the court costs. In case of suit, you agree the venue shall be in Multnomah County, OR.
WAIVER OF CONFIDENTIALITY: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.
FINANCE CHARGE: A finance charge will be imposed on each past due charge on your account, which has not been paid within sixty days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one and one half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE OF EIGHTEEN PERCENT (18%). The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits to the account during that time. The minimum finance charge is $0.50. If you have insurance, the finance charge will not be applied to outstanding insurance claims.

Medical History **Name**_____

Are you allergic to any of the following? __Aspirin __Penicillin __Codeine __Acrylic __Metal __Latex __Local Anesthetic __Other, Please explain_____

Are you in good general health?_____

Have you been under the care of a Physician within the past two years?_____

Have you ever had a serious illness? If so, what?_____

Have you taken any medications for the following conditions:

___Anticoagulants (blood thinners)	___Cortisone (steroids)	___Osteoporosis
___Antidepressants	___Heart Condition	___Pain
___Asthma or Emphysema medication	___Hormones or birth control	___Thyroid
___Blood Pressure	___Insulin	

List other medications_____

Have you ever had any hospitalizations or surgery? (list)_____

Women: Are you pregnant now?_____Nursing?_____

Do you use tobacco?, If so, how many packs a day?_____

Do you use alcohol? If so, how many drinks per week?_____

Do you use recreational drugs?_____

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

___Anemia	___Diabetes	___Heart Surgery	___Seizures
___Asthma	___Drug Addiction	___Hepatitis	___Sickle Cell Disease
___Artificial Joint	___Emphysema	___High Blood Pressure	___Stomach Problems
___Artificial Heart Valve/Stent	___Epilepsy	___Kidney Problems	___Stroke
___Arthritis	___Fainting Spells	___Multiple Sclerosis	___Thyroid Disease
___Blood Transfusion	___Fibro Myalgia	___Psychiatric Treatment	___Tuberculosis
___Cancer	___Glaucoma	___Radiation Treatment	___Venereal Disease
___Chest Pain (angina)	___Heart Murmur	___Rheumatic Fever	___Ulcers
___Chemotherapy	___Heart Pacemaker	___Rheumatism	

Financial/Payment Policy

PAYMENTS: Unless we approve other arrangements in writing, **payment is due at the time of service.** If you have insurance, and your insurance payment estimate is less than they actually pay, we will bill you for the remainder. The balance on your statement is due and payable on the date of issue, and is past due if not received within two weeks.

PAYMENT OPTIONS:

- Cash/Check Discount-5% discount for payment in full by cash or check at the time of service if there is **not insurance**
- Pay full patient portion at the time of service. If the procedure requires 2 appointments, pay in full at the first appointment.
- For procedures requiring 2 appointments, pay half of treatment fee at the first appointment and the second half at the final appointment. If you have insurance, pay the half of the estimated portion at the first appointment, and the second half at the final appointment.
- Credit Card Payment Options (with a signed authorization form and established payment history with our office). We allow you to make 3 equal installments: 1/3 payment due at the first appointment, 1/3 due 30 days later and the remaining balance sixty days from the initial appointment. Signed authorization allows office personnel to charge these payments to your credit card on the due dates.
- Zero % interest-Care Credit-if you are interested in an extended payment plan, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee and no prepayment penalty for services over $300. You can apply at www.carecredit.com
- Senior discount-5% discount for services paid by check, 3% for credit card, for age 62 and older if there is no insurance.
- RETURNED CHECKS: There is a fee (currently $25) for any checks returned by the bank.

I acknowledge that I have read, and agree to the above financial terms

Signature_____ Date_____