WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental heathcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

SS #/SIN _____ E-Mail _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS #/SIN _____

Address _____ E-Mail _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other 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.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card _____ Visa _____ MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

BULL MOUNTAIN
DENTAL IMAGES

DENTAL HISTORY

Doctor Use

Do you presently have or have you had:

		Yes	No	Unsure
1.	Pain or discomfort in the mouth, face, or jaws?	☐	☐	☐
2.	Bleeding or sensitive gums?	☐	☐	☐
3.	Aching of sensitive teeth?	☐	☐	☐
4.	Have you had an injury to your face or jaw?	☐	☐	☐
5.	Have you had serious trouble associated with any previous dental treatment?	☐	☐	☐
6.	Do you feel nervous or uneasy about having dental treatment?	☐	☐	☐

7. Date of last dental treatment: _____

My dental problem NOW is: _____

_____

MEDICAL HISTORY

Doctor Use Only

8.	Have you been a patient in a hospital during the past two years?	☐	☐	☐
9.	Have you been under the care of a medical doctor in the past two years?	☐	☐	☐
10.	Do you use tobacco products?	☐	☐	☐
11.	Do you use alcoholic beverages?	☐	☐	☐
12.	Do you use recreational or street drugs?	☐	☐	☐
13.	Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? If so, please list:	☐	☐	☐

Drug:	Dose/Frequency:	Reason for Taking:

14.	Do you have any allergies (i.e., itching, rash, swelling of hands, eyes, or feet), or are you made ill by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications?	☐	☐	☐
15.	Have you ever had excessive bleeding requiring special treatment?	☐	☐	☐
16.	When you walk upstairs or take a walk, do you ever have to stop because of chest pain?	☐	☐	☐
17.	Do your ankles swell during the day?	☐	☐	☐

	Yes	No	Unsure
18. Do you use more than two pillows to sleep?	☐	☐	☐
19. Do you wake up short of breath?	☐	☐	☐
DO YOU PRESENTLY HAVE, OR HAVE YOU HAD:			
20. High blood pressure?	☐	☐	☐
21. Heart disease, heart attack, or stroke?	☐	☐	☐
22. Angina pectoris (chest pain)?	☐	☐	☐
23. Heart murmur?	☐	☐	☐
24. Rheumatic fever?	☐	☐	☐
25. Congenital heart disease?	☐	☐	☐
26. Artificial heart valve or artificial joint?	☐	☐	☐
27. Fast, irregular heartbeat?	☐	☐	☐
28. Pacemaker?	☐	☐	☐
29. Scarlet fever?	☐	☐	☐
30. Tuberculosis (TB)?	☐	☐	☐
31. AIDS or HIV antibody?	☐	☐	☐
32. Hemophilia, anemia or other blood disease?	☐	☐	☐
33. Cold sores?	☐	☐	☐
34. Venereal disease (syphilis, gonorrhea, herpes, etc?	☐	☐	☐
35. Breathing problems, such as asthma, emphysema, hay fever, or sinus trouble?	☐	☐	☐
36. Diabetes (low or high blood sugar)?	☐	☐	☐
37. Thyroid disease (low or high hormone level)?	☐	☐	☐
38. Are you on a special diet or have you had a significant weight change in the past year?	☐	☐	☐
39. Stomach problems, ulcers, or irritable bowel?	☐	☐	☐
40. Liver disease, hepatitis, or yellow jaundice?	☐	☐	☐
41. Arthritis or rheumatism?	☐	☐	☐
42. Mental illness depression, epilepsy (seizure), fainting or dizzy spells?	☐	☐	☐
43. Kidney disease or dialysis?	☐	☐	☐
44. Cancer or other tumor?	☐	☐	☐
45. Cancer treatment, such as radiation or chemotherapy?	☐	☐	☐
46. Do you have a history of genetic, congenital, or family type disorder?	☐	☐	☐

BULL MOUNTAIN
DENTAL IMAGES

47. Do you have any disease, condition or problem not listed? . ☐ ☐ ☐

48. Women:

Are you pregnant now? ..... ☐ ☐ ☐

Are you currently using a prescription-type contraceptive?.. ☐ ☐ ☐

Dental Hx _____

_____

_____

Medical Summary

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct.

Signature _____ _____

Patient or Guardian *Relationship to patient*

Signature _____

Reviewing Doctor *Date*

Initial Vital Signs

Temp. _____ Pulse _____ Resp. _____ B.P. _____ _____

Signature

Medical History - Physical Evaluation Update

Changes _____ Date_____

Temp. _____ Pulse _____ Resp. _____ B.P. _____ _____

Signature

Changes _____ Date_____

Temp. _____ Pulse _____ Resp. _____ B.P. _____ _____

Signature

Changes _____ Date_____

Temp. _____ Pulse _____ Resp. _____ B.P. _____ _____

Signature

BULL MOUNTAIN
DENTAL IMAGES

Rod Johnson, DMD and Joel Fast, DMD

Smile Evaluation Form

	Y	N
Do you like the appearance of your teeth, your smile?	☐	☐
Are your teeth all in alignment (straight)?	☐	☐
Do you have spaces between your teeth that you do not like?	☐	☐
Do you like the color of your teeth?	☐	☐
Are any of your teeth chipped/protruding/hidden?	☐	☐
Are your teeth wearing on the biting surfaces?	☐	☐
Do you like the shape of your teeth?	☐	☐
Are there old fillings or dental work you don't like looking at?	☐	☐
What would you like to change most in the appearance of your teeth?	☐	☐

How would you like your teeth to look?

_____

_____

Thank You for taking the time to share with us a little more about your smile.

11815 SW King James Pl #10 Tigard, OR 97224 (503)968-6101*