Randy Allen Castle DMD, PC

2350 SW Multnomah Blvd
Portland, OR 97219

WWW.SWportlanddentist.com
DrCastle@SWportlanddentist.com

Ph. (503) 245-3515
Fx. (503) 244-3621

NEW PATIENT REGISTRATION

Welcome!
Thank you for choosing us.
We are committed to providing every adult and child with the highest quality oral healthcare in the most gentle, efficient, and cost effective manner possible. The more we know about you, the better we can help you.

Please complete these registration forms to the best of your knowledge.

PATIENT INFORMATION

Patient's Name_____
First Middle Last

Preferred Name_____
Which of the following describes your current status?

☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Minor

SSN _____-_____-_____ **DOB** ___-_____-_____

Address _____

City _____

State _____ Zip _____

Phone (home) (_____) _____

Phone (cell) (_____) _____

Phone (work) (_____) _____

Email _____

Employer_____

Position _____

Responsible Party _____

Responsible SSN _____

Method of Payment

☐ Insurance ☐ Cash ☐ Credit Card
☐ CareCredit ☐ Check

Parent/guardian's name if patient is a minor:

_____

Other family members who are patients here:

_____

_____

_____

DENTAL INSURANCE 1st COVERAGE

Employee Name _____

DOB _____ SSN _____

Employer_____

Insurance Co _____

Address _____

City _____

State _____ Zip _____

Phone # (_____) _____

Group # _____

DENTAL INSURANCE 2nd COVERAGE

Employee Name _____

DOB _____ SSN _____

Employer_____

Insurance Co _____

Address_____

State _____ Zip _____

Phone # (_____) _____

Group # _____

In case of an emergency, please notify (Name/Phone)

_____

_____

_____

Whom may we thank for this referral?

_____

Would you like to receive appointment reminders by Phone / Text / Email (please circle one).

FINANCIAL RESPONSIBILITY

Dr. Castle and all of his staff are committed to giving you superior dental care and we want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan, as well as our financial policy. Carefully read the following and let us know if you have any questions.

The insurance company contract is between you, your employer or whoever pays for the plan, and the insurance company. We will bill your insurance plan and do all that we can to help you obtain the maximum benefit from your insurance company, but the responsibility of payment will remain with you. In order for us to bill your insurance company, you must provide us with complete information about your plan, including any necessary forms, group numbers, phone numbers, and addresses.

Most dental insurance plans do NOT cover 100% of your treatment cost. Patients are expected to pay the estimated non-covered portion at the time of service. If your insurance company has not paid within 90 days of treatment, you will need to pay this account in full to this office. We will then reimburse you if and when your insurance company pays. This office can make no guarantees of the insurance plan's estimate of payment. This office does not absolve the patient of responsibility for the charges in full for treatment provided.

Patients who do not participate in an insurance plan are expected to pay for services at the time of delivery.

We accept: Visa, MasterCard, American Express, Discover, Cash, Check, and CareCredit.

All accounts over 60 days will be assessed a 1.5% interest charge per month (18% APR).
Delinquent accounts will be referred to a collection agency at the discretion of the office manager. If your account is turned over to a collection agency, an additional charge of $75 will be added to cover collection costs.

There will be a $25.00 fee for all returned checks.

You must give us at least **48 hours notice** if you are unable to make your appointment. **Failure to provide at least 48 hours notice will result in a $50.00 fee that will be added to your account and must be paid prior to any further treatments.**

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Randy Allen Castle DMD, PC to submit claims to my insurance carrier for all services rendered. I direct third party payers (insurance companies) to issue payment directly to Randy Allen Castle DMD, PC.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

Print full name (Patient or responsible person if patient is a minor) Date of Birth

Signature Date

ADULT MEDICAL HISTORY

		DOCTOR'S NOTES
1.Your physician's name _____		
Phone _____		
Address_____		
_____		
2. Have you ever had a serious illness or operation?.....	YES NO	
3. When was your last complete physical exam? _____		
4. Are you currently being treated/monitored for a specific condition by your physician?.....	YES NO	
5. Are you taking any medication, including birth control?.....	YES NO	
6. Do you have any known allergies?.....	YES NO	
7. Are you allergic to any specific medications or substances?.....	YES NO	
8. Do you have any problem with penicillin, antibiotics, or anesthetics?.....	YES NO	
9. Have you been treated for or have you been told you might have heart disease?.....	YES NO	
10. Have you ever had a stroke?.....	YES NO	
11. Do you have a pacemaker or an artificial heart valve?.....	YES NO	
12. Are you aware of any heart problems as a child?.....	YES NO	
13. Have you ever had rheumatic fever?.....	YES NO	
14. Have you ever been advised to be premedicated with antibiotics prior to dental treatment?.....	YES NO	
15. Have you ever had surgery, radiation treatment, or chemo therapy treatment for a tumor, growth, or other condition?.....	YES NO	
16. Do you have high or low blood pressure?.....	YES NO	
17. Do you have inflammatory diseases, such as arthritis, rheumatism, or lupus?.....	YES NO	
18. Do you have any artificial joints or prosthesis?.....	YES NO	
19. Do you have any blood disorders, such as anemia, leukemia, etc.?.....	YES NO	
20. Have you ever bled excessively after being cut or injured?.....	YES NO	
21. Do you have any stomach problems?.....	YES NO	
22. Do you have any kidney problems?.....	YES NO	
23. Do you have any liver problems?.....	YES NO	
24. Are you diabetic, or borderline diabetic?.....	YES NO	
25. Do you have asthma?.....	YES NO	
26. Do you have epilepsy or seizure disorders?.....	YES NO	
27. Do you have AIDS or have you tested positive for HIV?.....	YES NO	
28. Have you ever had hepatitis?.....	YES NO	
29. Have you ever had a blood transfusion?.....	YES NO	
30. Have you ever had tuberculosis?.....	YES NO	
31. Do you use any tobacco products?.....	YES NO	
32. Do you consume alcoholic beverages?.....	YES NO	
33. Are you pregnant or suspect that you may be?.....	YES NO	
34. Do you have any disease, condition, or problem not listed?.....	YES NO	
35. Is there anything else we should know about your health that we have not covered?.....	YES NO	
36. Would you like to speak to the Doctor privately about any concerns?....	YES NO	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient signature Printed Name Date

PAST DENTAL HISTORY

		DOCTORS NOTES
1. Purpose of initial visit? _____		
2. Are you aware of any dental problems?.....	YES NO	
If yes, please explain_____		
3. How long since your last dental visit? _____		
4. What was done at that time? _____		
5. What is your previous dentist's name? _____		
6. Have you made regular visits to a dentist?.....	YES NO	
How often? _____		
7. Were dental x-rays taken at your last dental appointment?.....	YES NO	
8. Have you lost any teeth?.....	YES NO	
Why? _____		
9. Have any lost teeth been replaced?.....	YES NO	
10. Are you happy with the replacement(s)?.....	YES NO	
11. Have you ever had any problems with previous dental treatment?.....	YES NO	
12. Do you clench or grind your teeth?.....	YES NO	
13. Does your jaw click or pop?.....	YES NO	
14. Do you have pain or soreness in the muscles of your face or around your ears?.....	YES NO	
15. Do you have frequent headaches, neck aches, or shoulder aches?.....	YES NO	
16. Does food get caught between your teeth?.....	YES NO	
17. Circle any of the following that your teeth are sensitive to: Hot Cold Sweets Pressure/Biting		
18. Do your gums bleed or hurt?.....	YES NO	
19. How often and when do you brush your teeth? _____		
20. Do you use dental floss?.....	YES NO	
How often? _____		
21. Are any of your teeth loose, tipped, or shifted?.....	YES NO	
22. Do you have any discolored teeth that bother you?.....	YES NO	
23. Do you feel your breath is offensive at times?.....	YES NO	
24. Have you ever had gum treatment or surgery?.....	YES NO	
25. Do you feel good about your teeth in general?.....	YES NO	
26. Are you happy with the appearance of your teeth?.....	YES NO	
27. Have you had any unpleasant dental experiences?.....	YES NO	
28. List anything about dentistry that you strongly dislike: _____ _____		
29. Do you have any dental questions or concerns?.....	YES NO	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient signature Printed Name Date