Oregon Periodontics PC
SPECIALISTS IN PERIODONTICS & DENTAL IMPLANTS

Patient Information

Patient's Legal Name_____Nickname_____Birthdate_____Sex_____Gender Identity____

Address_____Social Security #_____

Home Phone_____Work Phone_____Mobile Phone_____

Email Address_____Employer_____Occupation_____

Responsible Party Information

Name_____Birthdate_____Social Security #_____

Address_____Phone_____

Employer_____Occupation_____

Spouse's Name_____Birthdate_____Social Security #_____

Email Address_____Employer_____Occupation_____

Insurance Information

Primary Subscriber_____ID#_____Birthdate_____

Employer Group Name_____Group #_____

Primary Insurance Company _____Claim Address_____

Primary Insurance Company Phone #_____

Secondary Subscriber_____ID#_____Birthdate_____

Employer Group Name_____Group #_____

Secondary Insurance Company _____Claim Address_____

Secondary Insurance Company Phone #_____

Emergency Information

Name of nearest relative not living with you_____

Address_____Phone #_____

I certify the above to be true and correct to the best of my knowledge.

Signature (Patient, Parent or Legal Guardian)_____Date_____

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Medical History

Patient_____**Birthdate** _____**Primary Physician**_____**Phone**_____

Check an answer for each question:

☐ Yes ☐ No Any change in your health in the last two years? Date of last physical exam?_____

☐ Yes ☐ No Are you currently under the care of a Physician?
If yes, describe your treatment:_____

☐ Yes ☐ No Have you had any medical treatment or physician visit of any kind in the last two years?
If yes, describe:_____

☐ Yes ☐ No Have you ever had any surgical operation of any kind?
If yes, describe:_____

☐ Yes ☐ No Were you transfused at that time?

☐ Yes ☐ No Have you been advised by a physician of the need for any type of surgery or treatment?
If yes, describe?_____

☐ Yes ☐ No Are you taking any bisphosphonate inhibitors (ie: Actonel, Boniva, Fosamax, Reclast, Zometa)?

☐ Yes ☐ No Are you taking any erectile dysfunction drugs? (ie: Cialis, Levitra, Viagra)?

☐ Yes ☐ No Have you ever had an allergic reaction or been told not to take any medication?
If yes, describe:_____

☐ Yes ☐ No Are you currently taking any prescription drugs of any kind?
If yes, what:_____

☐ Yes ☐ No Are you currently taking any nonprescription drugs of any kind?
If yes, what:_____

☐ Yes ☐ No Are you taking daily aspirin or blood thinners/anticoagulants**?** (Coumadin, Warfarin, Eliquis)
If yes, what:_____

☐ Yes ☐ No Are you pregnant? Anticipated delivery date:_____

☐ Yes ☐ No Do you use any tobacco product? Daily intake:_____

☐ Yes ☐ No Do you wear contact lenses?

☐ Yes ☐ No Do you have anxiety with dental appointments ? On a scale of 1 to 10_____

Do you have, have you had, or been treated for, any of the following?

☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Rheumatic Fever
☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Mitral Valve Prolapse
☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Heart Murmur
☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Cancer
☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No	Family History of Heart Problems
☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Artery Replacement
☐ Yes	☐ No	Epilepsy, Seizures	☐ Yes	☐ No	Ulcers
☐ Yes	☐ No	Hypothermia	☐ Yes	☐ No	HIV
☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No	Anorexia, Bulimia
☐ Yes	☐ No	Allergy	☐ Yes	☐ No	Hip/Joint Replacement Date_____
☐ Yes	☐ No	Ear Infections	☐ Yes	☐ No	Anemia, Sickle Cell Disease
☐ Yes	☐ No	Chronic Sinus	☐ Yes	☐ No	Kidney Disorder
☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No	Respiratory Problems, Asthma
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Family history of Diabetes
☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Hemophilia, Blood Disorder
☐ Yes	☐ No	Enzyme Deficiency	☐ Yes	☐ No	Aids Related Complex (ARC)
☐ Yes	☐ No	Metal Sensitivity	☐ Yes	☐ No	Panic Attack Phobia, Nervousness
☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No	Thyroid Condition
☐ Yes	☐ No	Chronic Diarrhea	☐ Yes	☐ No	Venereal Disease, Herpes II
☐ Yes	☐ No	Chemical Dependency	☐ Yes	☐ No	AIDS

I certify the above to be true and correct to the best of my knowledge.

Signature_____Date_____

Doctor/Date _____ _____ _____ _____ _____

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HEALTH INFORMATION PRIVACY PRACTICES ACKNOWLEDGMENT AND CONSENT

I understand that the Oregon Periodontics, PC office (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices will be available in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:_____ Date: _____
(Patient, Parent or Legal Guardian)

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SIGNATURE ON FILE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize
(Name of Insured)

_____, to pay and hereby
(Name of Insurance Company)

assign directly to Oregon Periodontics, PC all dental benefits, if any, otherwise payable to me for services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to Oregon Periodontics, PC. Authorization is hereby given to release all information necessary to the payment of said benefits.

_____
(Authorized Signature of Covered Person/Employee) (Date)

_____
(Authorized Signature of Patient, Parent or Legal Guardian) (Date)

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REQUEST FOR RELEASE OF RECORDS

I, _____, hereby request and give my permission to Oregon Periodontics, PC to provide Dr. _____ any and all information he/she (Either referring Dentist and/or Medical Doctor) requests with respect to dental treatment. A photograph of this release will be as effective and valid as the original.

Signed _____ Date _____
(Patient)

Signed _____ Date _____
(Parent or Legal Guardian of the Patient)

Patient Name _____

Guardian Name _____

Address _____

Phone _____

PHOTO RELEASE

As a dental specialist, part of Oregon Periodontics, PC's professional responsibility is to educate the local dental community in Periodontics and Oral Implantology.

I give my permission to Oregon Periodontics, PC to use my diagnostic photographs, radiographs and/or study casts for purpose of demonstration of dental techniques. No identifying characteristics will be included in these materials. *This release is not an authorization for advertising purposes*, but to assist in the education of dental professionals in the specialty field of Periodontics and Implantology only.

Thank you.

_____
(Authorized Signature Patient, Parent or Legal Guardian) (Date)

Thank you for your time and effort

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Dental Treatment Agreement

Appointments:
All patients are seen by appointment, and we make every effort to see patients at their scheduled time. We realize that your time is valuable and we do our best to respect your time, and ask that you do the same in return. Due to the nature of surgery, appointments which are cancelled with little notice are very expensive for our practice. For this reason, we require two full weeks' notice (Monday through Friday) if you need to change or cancel an appointment. If less than two full weeks' notice is received, a ***cancellation fee of $500.00*** will be assessed for surgical and scaling/root planing appointments.

Fees and payment:
The fees ***we quote are estimates only***. If treatment should change, these fees will also change, and we will notify you of these changes. Payment is required at the time of service. We accept cash, check, MasterCard, Visa, Discover and Care Credit. For our patients without insurance, we offer a 5% courtesy discount for surgical treatment when paid in full with check or cash (debit not included) on the day of treatment. All accounts over 60 days will be charged a monthly interest fee of 1 ½% (an annual percentage rate of 18%). Delinquent accounts will be referred for collection's procedures after 120 days.

Insurance:
Insurance is a contract between the patient and the insurance company. As a courtesy, we will assist you in ***estimating*** the portion of treatment your insurance company may pay; ***however, all fees are the responsibility of the patient regardless of insurance.*** For periodontal treatment, we will collect your *estimated* portion at the time of treatment and bill your insurance for you. We will gladly provide any necessary information to your insurance; ***however, any remaining balance becomes the responsibility of the patient after 60 days.*** For implant ($500) and Stravix/BIO4 services ($650), a deposit is required at scheduling. These services require the purchase of medical devices in advance of the surgery, hence the advance payment. We will gladly, and as a courtesy, bill your insurance company.

Financial Agreement:
I agree to pay for services rendered by Oregon Periodontics, PC according to Oregon Periodontics, PC's terms and fees. If my insurance company denies payment for any reason, I agree to be personally and fully responsible for all fees. I have read, understand, and agree to the above terms.

_____
Print Patient's Name

_____ _____
Patient, Parent or Legal Guardian's Signature Date