OREGON CITY
FAMILY DENTISTRY
COSMETIC | IMPLANTS | children

MEDICAL HISTORY

Patient Name: _____ **DOB:** _____

Please rate your current physical health (1-10, 10 being best)? _____ Date of Last Physical exam _____

Have you been hospitalized or undergone surgery of any kind? If yes, please describe _____

_____

_____

Have you ever suffered a major head or neck injury? **Yes** **No** If yes, please explain:

_____

Are you currently taking any drugs or medications? **Yes** **No** If yes, please list:

_____

_____

_____

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? **Yes** **No**

Do you take, or have you taken, Phen-Fen or Redux? **Yes** **No**

PLEASE INDICATE ANY ALLERGIES:

Aspirin Penicillin/Amoxicillin Latex Codeine Acrylic Metal Sulfa Drugs Local Anesthetics

Other:

_____

Do you use tobacco products? **Yes** **No** If yes, what kind and frequency: _____

Do you use controlled substances? **Yes** **No**

Women ONLY:

Pregnant/Trying to get pregnant **Yes** **No** Nursing **Yes** **No** Taking Oral Contraceptives **Yes** **No**

Health Conditions:

AIDS/HIV	**Yes** **No**	Artificial Heart Valve	**Yes** **No**	Breathing Problems	**Yes** **No**
Alzheimer's Disease	**Yes** **No**	Artificial Joint	**Yes** **No**	Bruise Easily	**Yes** **No**
Anaphylaxis	**Yes** **No**	Asthma	**Yes** **No**	Cancer	**Yes** **No**
Anemia	**Yes** **No**	Blood Disease	**Yes** **No**	Chemotherapy	**Yes** **No**
Arthritis/Gout	**Yes** **No**	Blood Transfusion	**Yes** **No**	Chest Pains	**Yes** **No**

Cold Sore/Fever Blisters	Yes	No	Heart Pacemaker	Yes	No	Recent Weight Loss	Yes	No
Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No	Renal Dialysis	Yes	No
Convulsions	Yes	No	Hemophilia	Yes	No	Rheumatic Fever	Yes	No
Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Rheumatism	Yes	No
Diabetes Type 1	Yes	No	Hepatitis B or C	Yes	No	Scarlet Fever	Yes	No
Diabetes Type 2	Yes	No	Herpes	Yes	No	Shingles	Yes	No
Drug Addiction	Yes	No	High Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Easily Winded	Yes	No	High Cholesterol	Yes	No	Spina Bifida	Yes	No
Emphysema	Yes	No	Hives or Rash	Yes	No	Stomach/Intestinal Disease	Yes	No
Epilepsy or Seizures	Yes	No	Hypoglycemia	Yes	No	Stroke	Yes	No
Excessive Bleeding	Yes	No	Irregular Heartbeat	Yes	No	Swelling of Limbs	Yes	No
Excessive Thirst	Yes	No	Kidney Problems	Yes	No	Thyroid Disease	Yes	No
Fainting Spells/Dizziness	Yes	No	Leukemia	Yes	No	Tonsilitis	Yes	No
Frequent Cough	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Frequent Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Tumors/Growths	Yes	No
Frequent Headaches	Yes	No	Lung Disease	Yes	No	Ulcers	Yes	No
Genital Herpes	Yes	No	Mitral Valve Prolapse	Yes	No	Venereal Disease	Yes	No
Glaucoma	Yes	No	Osteoporosis	Yes	No	Yellow Jaundice	Yes	No
Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No			
Heart Attack	Yes	No	Parathyroid Disease	Yes	No			
Heart Failure	Yes	No	Psychiatric Care	Yes	No			
Heart Murmur	Yes	No	Radiation Treatments	Yes	No			

Have you ever had any serious illness not listed above? Yes No

If yes, please explain: _____

Comments:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Parent/Guardian (if minor):

X_____ Date: _____

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PATIENT REGISTRATION
(CONFIDENTIAL)

Today's Date: _____

Patient Name: _____ DOB: _____ Age: _____

Spouse/Parent Name: _____ DOB: _____

Marital Status: S M D W P Sex: M F Other

How would you like to be addressed? _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell: _____ Work: _____

Best phone number to reach you: Home Work Cell How would you like appointment reminders? Phone Text Email

Email Address: _____

Employer: _____ Occupation: _____

Person Responsible for account: Self _____ Other: _____

Whom may we thank for referring you? _____

Emergency Contact not living with you? _____ Phone# _____

****

PRIMARY DENTAL INSURANCE

Name of Insured: _____ Relationship: _____ Employer: _____

Date of Birth: _____ SSN/ID Number: _____ Group # _____

Insurance Company: _____ Phone: _____

Mailing Address: _____

SECONDARY DENTAL INSURANCE

Name of Insured: _____ Relationship: _____ Employer: _____

Date of Birth: _____ SSN/ID Number: _____ Group # _____

Insurance Company: _____ Phone: _____

Mailing Address: _____

PATIENT COMFORT

Our office strives to make your dental treatment as comfortable as possible. Please circle any of the following items that you may like to try:

Neck Pillow Ear Plugs Blanket Oral Sedation/IV Sedation Other

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FINANCIAL POLICY

We are committed to providing each patient with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. To do this, we need your assistance, and your understanding of our financial policy.

REGARDING NON-INSURED PATIENTS:
Payment in full is due at the time of service. We offer a discount on treatment for those patients enrolled in our Dental Savings Plan (DSP).

REGARDING INSURED PATIENTS:
We need current information to be able to process your insurance claim. Anytime your plan changes please call or email both sides of your new card one week prior to your appointment to allow us to get new benefits and update your information. While the filing of insurance claims is a courtesy to our patients, all charges are your responsibility from the date the service is rendered. Not all services are a covered benefit in all contracts.

****SECONDARY INSURANCE PLANS**: Please note that some plans have a Non-Duplication Clause. This often results in 'no payment' from that plan until your primary plan has been fully maxed out.
The patient will be responsible for their estimated out of pocket portion based on the primary insurance coverage. _____

I understand and agree that, **regardless of my insurance coverage,** I am ultimately responsible for the balance on my account for services rendered. _____

The parent/guardian bringing a child/dependent, and authorizing treatment is responsible for the payment of all charges.

We accept cash, check, and major credit cards except American Express. ~~(Effective 1/1/2025 a 3% fee will be applied to credit card transactions**~~) Financing though CareCredit and HFD is available for extended payment plans. Returned checks will be subject to an additional fee of $35.00. After 60 days, all accounts are subject to a finance charge of 1.5% of the unpaid balance, which is an annual percentage rate of 18%.
A charge of up to $100.00 may be applied for a missed appointment not cancelled with 24-hour notice.
We appreciate your trust and confidence in our office. Our goal is to make your visits as pleasant as possible. If you have any questions about the above information or are uncertain regarding insurance information, PLEASE do not hesitate to ask us. We are here to help you.

_____***I WILL PAY MY ESTIMATED AMOUNT IN FULL ON DAY OF TREATMENT*** (*With cash, check, debit, or credit card*)

I authorize payment of insurance benefits directly to Oregon City Family Dentistry.

Name (*PLEASE PRINT*) _____
Signature _____ Date _____

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HIPAA CONSENT FORM

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME: _____ **DOB:** _____

SOCIAL SECURITY #: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals

I understand that I have the right:

- To object to the use of my health information for directory purposes
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon

I request the following restrictions to the use of disclosure of my health information:

☐

_____

_____

_____

Printed Name of Patient: _____

Signature: _____ **Date:** _____

(Signature of Patient/Guardian or Legal Representative)

OREGON CITY
FAMILY DENTISTRY
PERSONALIZED, QUALITY CARE

CHILD DENTAL/MEDICAL HISTORY
(CONFIDENTIAL)

Patient Name _____

DENTAL HISTORY

Y | N 1. Is this the child's first visit to a dentist?

2. If not, how long since the last visit to the dentist? _____

Y | N 3. Does the child eat between meals?

Y | N 4. Does the child eat sweets, such as candy, soda pop or chewing gum?

Y | N 5. Does the child eat well balanced meals?

Y | N 6. Does the child brush teeth morning and bedtime?

Y | N 7. Do you live in an area without fluoridated water?

Y | N 8. Have teeth been treated with fluorides?

Y | N 9. How many cavities been noted in the past?

Y | N 10. Were any teeth (baby or permanent) removed by extraction?
Was is suggested that the space be maintained? Y | N
Was an appliance placed? Y | N

Y | N 11. Have there been any injuries to teeth, such as falls, blows, chips, etc?
If so, please describe _____

Y | N 12. Has the child had an unfavorable dental experience?

Y | N 13. Has anyone in the family, including parents, had braces?

Y | N 14. Has the child ever received a local anesthetic?

Y | N 15. Has the child ever had occlusal sealants?

MEDICAL HISTORY

Y | N 1. Is the child in good health?

Y | N 2. Is the child in care of a physician?
If yes, since when and why? _____

Y | N 3. Name of the physician: _____

Y | N 4. Has the child had any serious illness?
When _____ Why? _____

Y | N 5. Has the child had surgery?

Y | N 6. Is surgery contemplated?

Y | N 7. Is the child subject to profuse bleeding?

Y | N 8. Is the child subject to nervous disorders?
Fainting or dizziness? Y | N

Y | N 9. Does the child have any allergies? _____

Y | N 10. Is the child allergic to penicillin, antibiotics or other drugs?

Y | N 11. Is the child receiving any medication?
What _____

12. Has the child had a history of:

Y | N	Diabetes	Y | N	Kidney Infection	Y | N	Heart Trouble
Y | N	Rheumatic Fever	Y | N	Asthma	Y | N	Ear Infection

Y | N 13. Is there anything else we should know about this child's health that we have not covered in this form?

_____

Y | N 14. Would you like to speak to the Doctor privately about any problem?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Parent/Guardian _____ Date _____