Jordan Weber DENTAL

DENTAL HISTORY

Name_____ Age _____ Date _____

What is the reason for your visit today?_____

When was your last dental visit? _____ What for? _____

I routinely see my dentist every: 3 mo ☐ 4 mo ☐ 6mo ☐ 12mo ☐ Not Routinely ☐

Frequency of Brushing? _____Flossing? _____ Mouth rinse? _____

Frequency of sugary food/drink? Low ☐ Mod ☐ High ☐

Personal History

	YES	NO
Are you fearful of dental treatment? How fearful? On a scale of 1(least) to 10 (most) [____]_____	☐	☐
Have you had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
Have you had complications following past treatment? _____	☐	☐
Have you had orthodontic treatment (braces/retainers) or had your bite adjusted?_____	☐	☐
Have you had any teeth removed? _____	☐	☐

Gum and Bone Health

	YES	NO
Do you have sore or bleeding gums when brushing or flossing? _____	☐	☐
Have you been treated for periodontitis or told you have bone loss around your teeth? _____	☐	☐
Do you notice an unpleasant taste/odor in your mouth? _____	☐	☐
Have you had any gum recession? _____	☐	☐
Do you have loose teeth or difficulty eating an apple? _____	☐	☐

Tooth Structure

	YES	NO
Have you had cavities within the past 3 years? _____	☐	☐
Do you feel like your mouth is often dry or have difficulty swallowing food? _____	☐	☐
Do you notice any pitting or holes on the chewing surface of your teeth? _____	☐	☐
Are your teeth sensitive to hot, cold, biting pressure, eating sweets? _____	☐	☐
Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
Have you ever broken/chipped your teeth? How about a filling? _____	☐	☐
Do you frequently get food caught between your teeth? _____	☐	☐

Bite and Jaw

	YES	NO
Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? _____	☐	☐
When you bite your teeth together do you feel like your lower jaw is being pushed back? _____	☐	☐
Do you have difficulty chewing gum, carrots, nuts, bagels, baguettes or other hard food? _____	☐	☐
In the last 5 years have your teeth become shorter, thinner or worn? _____	☐	☐
Are your teeth becoming more crooked, crowded or overlapped? _____	☐	☐
Are your teeth developing spaces or becoming loose? _____	☐	☐
Do you have more than one bite or do you squeeze/shift your jaw to make your teeth fit together? _____	☐	☐
Do you chew ice, bite your nails, use your teeth to hold objects or have other habits? _____	☐	☐
Do you clench your teeth in the daytime or make them sore? _____	☐	☐
Do you have problems with sleep, wake up with a headache or an awareness of your teeth? _____	☐	☐
Do you wear or have you ever worn a bite appliance (night guard, retainer)? _____	☐	☐

Smile Characteristics

	YES	NO
Would you like to change anything about the appearance of your teeth? _____	☐	☐
Have you ever whitened (bleached) your teeth? _____	☐	☐
Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	☐	☐

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MEDICAL HISTORY

Name _____ Age _____

Emergency Contact Name _____Relation_____ Phone _____

Name of Physician and their specialty _____Date of Most Recent Physician Visit _____

What is your estimate of your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever had:	YES	NO
Hospitalization for illness or injury _____	☐	☐
Allergic reaction to:		
☐ Aspirin, ibuprofen, acetaminophen, codeine		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Sulfa		
☐ Local Anesthetic ("novocaine")		
☐ Fluoride		
☐ Metals (nickel, gold, silver_____)		
☐ Latex		
☐ Other _____		
Heart problems, or cardiac stent within last 6 months___	☐	☐
History of infective endocarditis _____	☐	☐
Artificial heart valve, repaired heart defect (PFO)_____	☐	☐
Pacemaker or implantable defibrillator_____	☐	☐
Artificial prosthesis (heart valve or joints)_____	☐	☐
Rheumatic or scarlet fever_____	☐	☐
High or Low Blood Pressure_____	☐	☐
Stroke (taking blood thinners)_____	☐	☐
Anemia or other blood disorder _____	☐	☐
Prolonged bleeding due to slight cut (INR >3.5) _____	☐	☐
Asthma_____	☐	☐
Breathing or Sleep Problems (i.e. snoring, sinus) _____	☐	☐
Kidney Disease_____	☐	☐
Liver Condition_____	☐	☐
Thyroid, parathyroid, or calcium deficiency _____	☐	☐
Hormone Deficiency_____	☐	☐
High Cholesterol or taking statin Drugs_____	☐	☐
Diabetes (HbA1c = _____)_____	☐	☐
Digestive Disorders (ie. Gastric reflux, ulcers)_____	☐	☐

	YES	NO
Osteoporosis/osteopenia (i.e. taking bisphosphonates) _	☐	☐
Arthritis _____	☐	☐
Glaucoma_____	☐	☐
Head or Neck Injury_____	☐	☐
Epilepsy, convulsions (seizures) _____	☐	☐
Neurologic Condition (attention deficit disorder) _____	☐	☐
Viral Infections/ cold sores _____	☐	☐
Any lumps or swelling in the mouth _____	☐	☐
Hives, skin rash, hay fever _____	☐	☐
Venereal Disease _____	☐	☐
Hepatitis (type_____)_____	☐	☐
HIV/AIDS _____	☐	☐
Tumor, abnormal growth _____	☐	☐
Radiation Therapy_____	☐	☐
Chemotherapy_____	☐	☐
Psychiatric Care_____	☐	☐
Antidepressant Medication_____	☐	☐
Emphysema, sarcoidosis _____	☐	☐
Tuberculosis_____	☐	☐

Are You:		
Presently being treated for any other illness _____	☐	☐
Aware of a change in your health (i.e. fever, new cough)_	☐	☐
Taking medication for weight control (i.e. fen-phen) ____	☐	☐
Experiencing frequent headaches _____	☐	☐
A current or past smoker/ smokeless tobacco user _____	☐	☐
FEMALE- taking birth control pills _____	☐	☐
FEMALE- pregnant _____	☐	☐
MALE- prostate condition _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (ie botox injection)

_____

List all Medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

In the future, please advise us of any change in your Health History

Patient's Signature_____ Date _____

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REGISTRATION

About You

Name_____ Birthdate _____
First Middle Last Preferred

Address _____ Social Security # _____
City State Zip code

☐ Home Phone _____ ☐ Cell_____ ☐ Work _____
Mark Box for Preferred Number

How did you hear about our office? _____

☐ Single ☐ Married ☐ Divorced ☐ Minor Email Address_____

Occupation _____Place of Employment_____

Emergency Contact Information

Emergency Contact: Name _____ Relation _____

Emergency Contact: Home Phone _____Emergency Contact: Cell Phone _____

Dental Insurance

If you will be using dental insurance, please complete the following:

Insurance Company Name _____ Group/Policy Number_____

Subscriber Name_____ Subscriber Birthdate _____
First Middle Last

Address of Subscriber _____ Social Security # _____
City State Zip code

Subscriber Employer _____ Subscriber ID Number _____

Subscriber's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Secondary Insurance: ☐ Yes ☐ No -if yes, please provide this info on an additional sheet

Appointment Cancellation Policy

We value your time and work diligently to keep your visit on schedule and as short as possible. In return, we ask that you arrive timely. If you must change your appointment, please provide us with 24 hours notice so that we can accommodate others. We reserve the right to assess a fee of $75 to patients who miss or cancel an appointment without a 24-hour notice.

Financial Policy

We can help you make decisions on how to best use your financial resources to improve your dental health. For all treatment we ask that you pay at the time of service, regardless of the payment method(s) you choose.

We offer several methods of payment:

- Cash or Check
- Credit or Debit card: Visa, MasterCard, Discover, American Express
- CareCredit - a third party financial institution with interest free financing

If you are not paying with dental Insurance:

We request your payment at the time of service. It is our policy to have our accounts paid in full within 60 days. If you need to make other arrangements, please do so in advance of your appointment. If you pay in full at the time of service with cash or check, we offer a 5% courtesy discount.

If you are paying with dental Insurance:

Please provide us with your most current dental insurance information. As a courtesy, we are happy to bill your insurance carrier to assist you in obtaining your benefits. However, we do ask that your portion, if any, be paid at the time of service. Should your insurance company decline or delay payment, you are held responsible for payment, in full, within 60 days of the date of service.

We count on you to know the terms of your coverage, as you are ultimately responsible for any fees incurred in this office. We do not accept responsibility for insurance company actions or decisions.

Policy Agreement & Consent of Disclosure

I understand and agree to the Appointment Policy and Financial Policy. In addition, I hereby authorize any available insurance benefits to be paid directly to JordanWeber Dental, and the release of my dental health care information for any treatment, payment and/or health care operations where it is necessary. For any dental care provided by JordanWeber Dental, which is not covered by insurance, I understand that I am obligated to JordanWeber Dental any uninsured cost. Finally, I certify that I have read or had read to me the contents of this form and understand there are risks and limitations to dental treatment.

Patient Name _____

Patient/Guardian Signature _____ Date _____

Receipt of Privacy Practices

Information about the usage and disclosure of your protected health information is provided in our Notice of Privacy Practices, attached. Please review this Notice before you sign this consent.

Your protected information will be shared with parents and/or legal guardians if you are under the age of 18. For patients 18 and older, we will share information with other members listed on your insurance account, should they inquire, unless requested otherwise. This includes, but is not limited to your spouse/partner, parents and/or siblings.

I, _____, have been offered a copy of JordanWeber Dental's PRIVACY POLICY NOTICE and consent to the use of my protected health information to carry out treatment, payment activities and healthcare operations as explained.

You May Refuse to Sign This Acknowledgement

Patient Name _____

Patient/Guardian Signature _____ Date _____

_____For Office Use Only_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify)

_____

_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2021 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials the health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as email, voicemail messages, postcards, or letters).
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $25.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).
Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate if you choose to file a complaint.

Contact Officer: Anne Thompson
Telephone: 503-692-6535
E-mail: info@jordanweberdental.com
Address: Heather N Weber DDS PC
18789 SW Boones Ferry Rd #4, Tualatin, OR 97062