Strauss Dental
802 Molalla Avenue • Oregon City, OR 97045
(503) 656-2139

Communication Authorization

Patient Name: _____

There may be times when Dr. Strauss and staff may need to contact you regarding your appointments, dental care, financial information, appointments, or other communications. Please authorize of the following methods of communication:

I, authorize Dr. Strauss and staff to contact me and leave detailed message(s) at the following location(s):

☐ home#:_____ ☐ work#:_____

☐ cell#:_____ ☐ email:_____

**** Preferred method to contact me regarding appointment reminder messages:**_____

☐ I wish to name a representative(s) to act on my behalf and/or to speak with Dr. Strauss and staff regarding my care, treatment, financial information, appointments or other communication.

Representative

Initial

Name _____ Relationship _____
Phone #_____ _____

Initial

Name _____ Relationship _____
Phone #_____ _____

Initial

Name _____ Relationship _____
Phone #_____ _____

☐ I **DECLINE** to name a representative to act on my behalf; please **DO NOT** discuss my care with anyone other than as allowed by HIPAA regulations.

Signature:_____ **Date:**_____

Name & relationship to patient if other than self: _____

UPDATES (for office use only)

Date	Notes	Initial
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1 PATIENT INFORMATION

NAME:

ADDRESS:

CITY: | STATE | ZIP:

PHONE# HOME: | WORK: | EMPLOYER:

BIRTH DATE | MARRIED ☐ | SINGLE ☐

IF PATIENT IF A MINOR, PARENT OR GURDIANS NAME:

SCHOOL: | GRADE LEVEL:

2 DENTAL INSURANCE

Primary Coverage

Coverage for: Self ☐ Spouse ☐ Dependants ☐

INSURANCE COMPANY:

COMPANY ADDRESS:

INS. PHONE #: | GROUP#:

EMP. SOCIAL SECURITY #:

PERSON INSURED: | DATE OF BIRTH:

EMPLOYER:

Secondary Coverage

Coverage for: Self ☐ Spouse ☐ Dependants ☐

INSURANCE COMPANY:

COMPANY ADDRESS:

INS. PHONE #: | GROUP#:

EMP. SOCIAL SECURITY #:

PERSON INSURED: | DATE OF BIRTH:

EMPLOYER:

3 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

ADDRESS: | HOME PHONE#:

CITY: | STATE: | ZIP:

EMPLOYER: | WORK PHONE#: | SOCIAL SECURITY #:

DATE EMPLOYED: | DRIVERS LICENSE:

4 GETTING TO KNOW YOU

IS ANOTHER FAMILY MEMBER OR RELATIVE A PATIENT AT OUR OFFICE?
YES: ☐ NO: ☐ THEIR NAME:

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

NAME:

YOUR SPOUSE'S NAME:

ADDRESS | PHONE#:

SPOUSES OCCUPATION

CITY: | STATE:

YOUR OCCUPATION:

- I hereby authorize payment directly to the dental office of group insurance benefits otherwise payable to me.
- I understand that I am responsible for all costs of dental treatment performed.
- I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- I have received a copy of the office's Notice of Privacy Practices.

X _____ **DATE** _____

PATIENT SIGNATURE (parent or guardian if minor child)

Medical History

Patient Name_____ Date_____

Physicians Name_____ Phone_____

1. Have you been under the care of medical doctor during the past two years? Yes ☐ NO ☐
   a. If yes, for what?_____
   _____
2. Are you taking any prescribed or non-prescription medications? Yes ☐ NO ☐
   a. If yes, please list name and dose _____
   _____
3. Are you aware of having any allergic or adverse reaction to any medication? Yes ☐ NO ☐
   a. If yes, Allergic to what and type of reaction? _____
   _____

4. Do you now have, or have you ever had any of the following: Check "Yes" or "No" to each

Heart (surgery, Disease, attack) Yes ☐ No ☐	Ulcers..... Yes ☐ No ☐	Hep A, B, C..... Yes ☐ No ☐
Chest Pain..... Yes ☐ No ☐	Diabetes..... Yes ☐ No ☐	Venereal Disease..... Yes ☐ No ☐
Congenital Heart Disease..... Yes ☐ No ☐	Thyroid Problems..... Yes ☐ No ☐	AIDS..... Yes ☐ No ☐
Heart Murmur..... Yes ☐ No ☐	Glaucoma..... Yes ☐ No ☐	HIV Positive..... Yes ☐ No ☐
High Blood Pressure..... Yes ☐ No ☐	Anemia..... Yes ☐ No ☐	Cold Sore, Blisters..... Yes ☐ No ☐
Mitral Valve Prolapse ..... Yes ☐ No ☐	Emphysema..... Yes ☐ No ☐	Bruise Easily..... Yes ☐ No ☐
Heart Pacemaker..... Yes ☐ No ☐	Tuberculosis..... Yes ☐ No ☐	Hemophilia..... Yes ☐ No ☐
Rheumatic Fever..... Yes ☐ No ☐	Asthma..... Yes ☐ No ☐	Kidney Disease..... Yes ☐ No ☐
Arthritis..... Yes ☐ No ☐	Hay Fever..... Yes ☐ No ☐	Liver Disease..... Yes ☐ No ☐
Cortisone Medicine..... Yes ☐ No ☐	Latex Sensitivity..... Yes ☐ No ☐	Neurological Disorder..... Yes ☐ No ☐
Swollen Ankles..... Yes ☐ No ☐	Allergies or Hives..... Yes ☐ No ☐	Epilepsy or Seizures..... Yes ☐ No ☐
Stroke..... Yes ☐ No ☐	Sinus Trouble..... Yes ☐ No ☐	Fainting or Dizzy Spells Yes ☐ No ☐
Artificial Joints..... Yes ☐ No ☐	Radiation Therapy..... Yes ☐ No ☐	Psychiatric Care..... Yes ☐ No ☐
Cancer..... Yes ☐ No ☐	Chemotherapy..... Yes ☐ No ☐	

5. Do you have or have you had any disease, condition, problem NOT listed? Yes ☐ NO ☐
   a. If yes, please list:_____
6. Do you use tobacco products? Yes ☐ NO ☐ Have you used them in the past? Yes ☐ NO ☐
7. Women: Are you pregnant? Yes ☐ NO ☐ Nursing? Yes ☐ NO ☐

I understand the above information is necessary to provide me with dental care to a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any changes to my health or medications.

Patient/Guardian Signature _____ Date_____

DENTAL HEALTH INFORMATION

Previous Dentist:_____ Date last treated _____

What is the reason for your visit today?_____

Do you presently have dental pain or discomfort? Please describe:_____

_____

Have you ever had any serious problems associated with dental treatment?..... Yes ☐ No ☐

If yes, please explain: _____

How often do you brush your teeth? _____ How often do you floss your teeth?_____

What texture brush do you use? Soft ☐ Medium ☐ Hard ☐ Electric ☐

Have you had injuries to your face, neck or jaw?.....Yes ☐ No ☐

Do you have problems with food catching between your teeth when you eat?.....Yes ☐ No ☐

DO YOU HAVE OR HAVE YOU EVER HAD: (check)

Gums that bleed when you brush or floss?.....	Have Now ☐	Have Had ☐	Don't Have ☐
Gums that are swollen or tender?.....	Have Now ☐	Have Had ☐	Don't Have ☐
Pain in any of your teeth when brushing or flossing?.....	Have Now ☐	Have Had ☐	Don't Have ☐
Treatment for periodontal (gum) disease?.....	Have Now ☐	Have Had ☐	Don't Have ☐
Pain when your teeth come in contact with hot or cold foods?.....	Have Now ☐	Have Had ☐	Don't Have ☐
Orthodontic treatment?.....	Have Now ☐	Have Had ☐	Don't Have ☐
Pain, clicking or popping in your jaw joints?.....	Have Now ☐	Have Had ☐	Don't Have ☐
Clench or grind your teeth while sleeping or during the day?.....	Have Now ☐	Have Had ☐	Don't Have ☐
Difficulty opening or closing your mouth?.....	Have Now ☐	Have Had ☐	Don't Have ☐

Do you like the appearance of your teeth?..... Yes ☐ No ☐

If no, what would you like to see different? _____

_____

Is there any treatment that was recommended by another dentist that was not completed?.....Yes ☐ No ☐

Do you expect to maintain your teeth for your lifetime?.....Yes ☐ No ☐

Do you have any particular concerns about the materials used to restore your teeth?_____

_____

Is there anything else that you would like the Doctor to be aware of concerning your past or present dental health?

_____

_____