PATIENT INFORMATION

Patient Information

Patient's Name____

Birthdate_________________________ Social Security #_________________________________

Address____Zip Code_______________

Home Phone_______________________________ Work Phone_____________________________

Mobile Phone______________________________ Email Address___________________________________

Employer____ Occupation______________________________

Responsible Party Information

Name (if other than patient) ____

Birthdate_________________________ Social Security #_________________________________

Employer____ Occupation______________________________

Spouse's Name____

Birthdate_________________________ Social Security #_________________________________

Employer____ Occupation______________________________

Insurance Information

Primary Subscriber____ID#__________________________

Employer Group Name_______________________________________ Group #_________________________

Primary Insurance Company ____

Primary Insurance Company Phone #____

Secondary Subscriber____ID#__________________________

Employer Group Name_______________________________________ Group #_________________________

Secondary Insurance Company ____

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________________

Oregon Periodontics, PC
MEDICAL HISTORY

Patient____ Date of Birth _____________ Date ______
Name of Physician____ Phone #_______________
When was your last physical exam?________________________________

Check an answer for each question:

____ Yes ____ No Any change in your health in the last two years?
____ 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?
For what?____
____ 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)?

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

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

____ 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, Plavix
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?
On a scale of 1 to 10 what is your anxiety level with dental appointments? ________
I certify the above to be true and correct to the best of my knowledge.
Signature____
Date___________________________________

Doctor/Date __________________ __________________ __________________ __________________

Oregon Periodontics, PC
Limited to Periodontics & Oral Implantology
11786 SW Barnes Rd., Suite 210
Portland, OR 97225
Phone 503-531-3550   Fax 503-531-3560

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 form 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 ____
____
Telephone ______________________________

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 or 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 collections 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 services, a $500.00 deposit is required two weeks prior to surgery date. Implant services require the purchase of medical devices in advance of the surgery.

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