CORVALLIS DENTAL GROUP

Patient Registration

PATIENT INFORMATION

Name Birthdate

Address City State Zip code

Occupation Home Phone Mobile Phone

Email

Preferred method of contact/appointment reminders: ☐ Phone ☐ Text ☐ Email

Spouse or Parent's Guardian's Name

Emergency Contact Relationship Phone

How did you hear about us? (please be specific)

Please present photo I.D. to receptionist

RESPONSIBLE PARTY

Name of person responsible for this account Relationship to patient

Address City State Zip code

Employer Phone Work Phone

Email Birthdate

Is this person currently a patient? ☐ Y ☐ N

PRIMARY DENTAL INSURANCE

Subscriber Name Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID # Group #

Insurance Co. Insurance Phone

Insurance Address City State Zip code

Employer Subscriber Birthdate

Please present insurance card to receptionist

SECONDARY DENTAL INSURANCE

Subscriber Name Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID # Group #

Insurance Co. Insurance Phone

Insurance Address City State Zip code

Employer Subscriber Birthdate

Please present insurance card to receptionist

Authorization and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company(ies) and assign directly to Corvallis Dental Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions whether manual or electronic. Corvallis Dental Group may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services.

Signature of patient (or parent/guardian if minor) Print Name of patient (or parent/guardian if minor

_____

Date

We appreciate the trust you have placed in us and would like to thank you for choosing our practice as your dental home. In a conscious effort to consider your financial options while maintaining a high level of professional care, we have established the following payment policy for our patients. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

PAYMENT OPTIONS

- Cash, check, most major credit cards accepted
- We also offer a 5% courtesy discount to patients who pay for their treatment in full the day of service with cash or check.
- **DENTAL INSURANCE:** We accept dental insurance and will be happy to bill the insurance carrier directly for you. **However, we do not, under any circumstances bill Medicare or Oregon Health Plan.** We ask that you assign benefits to us. We have found that dental insurance rarely pays 100% of the fee for service, therefore, it will be necessary to make arrangements for the estimated balance of your account. A statement will be sent to you each month to keep you informed of what payments have been received.
- **EXTENDED CREDIT:** Special Arrangements can be made to meet your individual needs. However, we are unable to carry accounts any longer than 90 days or 3 monthly payments. All extended credit must be arranged with our receptionist. For our patient's convenience, we do offer monthly payment options from Care Credit patient financing.

PLEASE NOTE

- **PAST DUE BALANCES:** Balances exceeding 90 days will be charged a service fee of 1.5% per month, which is equivalent to 18% per annum.

- **MISSED APPOINTMENTS:** An appointment is a reservation of our office and staff for your treatment needs. This time is deprived from someone else if we do not have adequate notice for cancellations. Please give us at least 24 hours notice if you cannot keep your appointment. We reserve the right to charge a $50.00 missed appointment fee. If non-cancelled appointments become a habit (more than 2 failed appointments in a year), we reserve the right to dismiss you as a patient from our office.

- **NSF CHECKS:** A fee of $15 will be charged for checks returned for "non-sufficient funds."

- If your insurance company does not pay within 60 days, Corvallis Dental Group reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you.

- It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit. If you do not have proof of active insurance at your visit, you will be considered a self-pay patient for that visit and payment will be due in full that same day.

- We attempt to make confirmation calls, send texts, and/or send emails at least 48 hours in advance of your scheduled appointment as a courtesy.

In the event your account is turned over to an outside agency for collection, you will be responsible for all collection fees, cost, and such additional sum as the court may deem responsible. I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Corvallis Dental Group. I understand regardless of any insurance coverage I may have; **I am responsible for payment of my account within the usual limits of this policy.**

Signature of patient (or party responsible for account) **Print Name** of patient (or party responsible for account)

Date:

Patient: _____ **Birthdate:** _____ **Date:**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

My signature confirms that I have been informed of my right to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of this office's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information.

☐ I hereby give Corvallis Dental Group authorization to release my information to the individuals listed below (i.e. spouse, guardian/caregiver, relative, friend):
Please list name and relationship to you:

☐ I do not wish my information to be discussed with anyone other than myself.

Signature Date

For Office Use Only

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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, 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

We are required by applicable federal and state law 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 health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2003 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.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. 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.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.

To Your Family and Friends: 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 a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

CORVALLIS DENTAL GROUP

Medical History

PATIENT NAME: _____ **Birthdate:** _____

Primary Physician: _____ **Phone Number:** _____

Are you currently under a doctor's care?	☐ Y ☐ N	**If yes, please explain:**
Have you been hospitalized or had any surgeries in the last 5 years?	☐ Y ☐ N	**If yes, please explain:**
Do you use tobacco products?	☐ Y ☐ N	**Type/Day/How long?**
Do you consume alcoholic beverages?	☐ Y ☐ N	**How often?**
Do you use recreational drugs?	☐ Y ☐ N	**If yes, list type:**
Have you had an unfavorable reaction following dental treatment?	☐ Y ☐ N	**If yes, please explain:**
Have you taken in the past 12 years, or are you currently taking, any bisphosphonate medications?	☐ Y ☐ N	**If yes, how long and what type:**
Are you taking any drugs, supplements, or medications?	☐ Y ☐ N	**If yes, please explain:**

Are you allergic to any of the following?

☐ **Penicillin** ☐ **Codeine** ☐ **Tetracycline** ☐ **Erythromycin**
☐ **Sulfa Drugs** ☐ **Metals** ☐ **Latex** ☐ **Dental Anesthetics**
☐ **Other** **Please explain:** _____

FEMALE: Are you

Pregnant? ☐ Y ☐ N **Nursing?** ☐ Y ☐ N **Taking oral contraceptives?** ☐ Y ☐ N

Do you have or have you experienced any of the following? Please check all that apply.

☐ Abnormal Bleeding	☐ Difficulty Breathing	☐ Kidney Disease	☐ Tuberculosis
☐ AIDS/HIV	☐ Digestive Disorder	☐ Liver Disease	☐ Ulcers/GERD
☐ Alcohol Addiction	☐ Drug Addiction	☐ Neurological Disorder	
☐ Alzheimer's or Dementia	☐ Emphysema	☐ Osteoporosis	
☐ Artificial Pins, Bones or Joints	☐ Epilepsy or Seizures	☐ Persistent Cough	HEART:
☐ Asthma	☐ Fainting	☐ Psychiatric Problems	☐ Arrythmia
☐ Blood Disease	☐ Glaucoma	☐ Radiation Therapy	☐ Artificial Heart Valve
☐ Blood Thinners	☐ Hay Fever	☐ Rheumatic Fever	☐ Chest Pains
☐ Blood Transfusion	☐ Headaches	☐ Scarlet Fever	☐ CHG
☐ Cancer/Tumors	☐ Hepatitis A	☐ Seizure Disorder	☐ Heart Attack
☐ Chemotherapy	☐ Hepatitis B	☐ Shingles	☐ Heart Disease
☐ Chicken Pox	☐ Hepatitis C	☐ Shortness of Breath	☐ Heart Murmur
☐ Cold Sores	☐ Herpes	☐ Sickle Cell Disease	☐ Heart Surgery
☐ Colitis	☐ High Blood Pressure	☐ STD	☐ Mitral Valve Prolapse
☐ Diabetes	☐ Hearing Problem	☐ Thyroid Disease	☐ Pacemaker
☐ Depression	☐ Hemophilia	☐ Tonsillitis	☐ Stoke/CVA

Please specify marked items and/or list any serious medical condition(s) not indicated above:

_____

Sleep Disorder Questionnaire:

Do you often feel tired, fatigued, or sleep during the day?	☐ Y ☐ N
Has any observed you stop breathing during your sleep?	☐ Y ☐ N
Do you snore loudly?	☐ Y ☐ N
Are you 50 years or older?	☐ Y ☐ N
Is your neck circumference greater than 16 inches?	☐ Y ☐ N

NOTE: Both doctor and patient are encouraged to discuss any and all relevant health issues prior to treatment. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays, models, or photos for scientific, teaching, or promotional purposes. By signing this form, I acknowledge that the information is true and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____

CORVALLIS DENTAL GROUP

Dental History

PATIENT NAME: _____ **Birthdate:** _____

Purpose of initial visit:					
Previous Dentist Name:		**Phone Number:**		**City/State:**	
Date of last dental visit:		**When was your last cleaning?**		**Were X-rays taken?**	☐ Y ☐ N
Date of last full mouth x-rays or panoramic:		**History of Gum Surgery?**	☐ Y ☐ N	**Removed or lost any teeth?**	☐ Y ☐ N
Have you been pre-medicated with antibiotics for dental treatment?	☐ Y ☐ N	**If yes, please list medication and dosage:**			

Are you nervous about dental treatment ☐ Y ☐ N **Have you used Nitrous Oxide?** ☐ Y ☐ N

How often do you brush? Select option **Are you using an electric or regular toothbrush?** Select option

Do you floss?	☐ Y ☐ N	**Do your gums bleed or hurt?**	☐ Y ☐ N
Do you have dry mouth?	☐ Y ☐ N	**Do you have sensitive teeth?**	☐ Y ☐ N
Does your jaw lock or pop?	☐ Y ☐ N	**Does food get caught in your teeth?**	☐ Y ☐ N
Do you clench or grind your teeth?	☐ Y ☐ N	**Do you have loose or separating teeth?**	☐ Y ☐ N
Do you have frequent headaches?	☐ Y ☐ N	**Have you had any orthodontic work?**	☐ Y ☐ N
Do you wear partials or dentures?	☐ Y ☐ N	**Do you have pain, tenderness, numbness or earaches?**	☐ Y ☐ N

Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth?	☐ Y ☐ N	**If yes, briefly explain:**	

Are you happy with the appearance of your smile? ☐ Y ☐ N
Do you have questions or concerns to talk to the doctor about? ☐ Y ☐ N

Please state question or concern:

By signing this form, I acknowledge that the information provided is true and accurate to the best of my knowledge.

_____

Patient Signature Relationship to patient

_____

Print Name Date