15160 NW Laidlaw Rd Ste 202
Portland, Oregon 97229
in Bethany Village
Tele: 503-533-2330
Fax: 503-533-2331
www.bethanydentistpdx.com

Hillside Dental at Bethany

Patient Information

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Birth Date: _____ Social Security Number: _____
Email Address: _____
Employer: _____
Previous Dentist's Name: _____
Current Physician's Name: _____

Responsible Party Information

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Birth Date: _____ Social Security Number: _____
Email Address: _____
Employer: _____

How did you find us?
☐ Bethany Family Values Magazine ☐ Brochure ☐ Internet ☐ Live nearby
☐ Referred by friend, family or another person ☐ Referred by insurance company ☐ Other
If you were referred, whom may we thank for referring you? _____

Dental History

Why have you come to the dentist today? _____
When was the last time you saw a dentist? _____

Do you have any of the following concerns?

☐ Frequent Headaches	☐ Gum Disease	☐ Jaw Joint (TMJ/TMD) Pain
☐ Hot/Cold Sensitivity	☐ Bleeding Gums	☐ Grinding or Clenching
☐ Sensitivity to Sweets	☐ Painful Gums	☐ Painful Teeth

Do you need to be premedicated with antibiotics before dental treatment? ◯ Yes ◯ No
Are you interested in a whiter smile? ◯ Yes ◯ No
Would you like to straighten your smile? ◯ Yes ◯ No
Do you have any metal fillings you would like to replace? ◯ Yes ◯ No

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Emergency Contact

Name: _____
Relation: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

I have dental insurance: ○ **Yes** ○ **No**

Primary Insurance Information

Subscriber Name: _____
Employer: _____
Insurance Company: _____
Subscriber Date of Birth: _____
Subscriber ID Number or Social Security Number: _____
Group ID Number: _____
Insurance Phone Number (on back of card): _____

Secondary Insurance Information

Subscriber Name: _____
Employer: _____
Insurance Company: _____
Subscriber Date of Birth: _____
Subscriber ID Number or Social Security Number: _____
Group ID Number: _____
Insurance Phone Number (on back of card): _____

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Patient Medical Information

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, drugs or herbal remedies? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No If yes, please explain: _____

Are you on a special diet? ◯ Yes ◯ No If yes, please explain: _____

Do you use tobacco? ◯ Yes ◯ No _____

Do you use controlled substances? ◯ Yes ◯ No _____

For Women: Are you pregnant/trying to get pregnant? ◯ Yes ◯ No _____

For Women: Are you taking oral contraceptives? ◯ Yes ◯ No _____

For Women: Are you nursing? ◯ Yes ◯ No

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯Yes ◯No	Cortisone Medicine ◯Yes ◯No	Hemophilia ◯Yes ◯No	Renal Dialysis ◯Yes ◯No
Alzheimer's Disease ◯Yes ◯No	Diabetes ◯Yes ◯No	Hepatitis A ◯Yes ◯No	Rheumatic Fever ◯Yes ◯No
Anaphylaxis ◯Yes ◯No	Drug Addiction ◯Yes ◯No	Hepatitis B or C ◯Yes ◯No	Rheumatism ◯Yes ◯No
Anemia ◯Yes ◯No	Easily Winded ◯Yes ◯No	Herpes ◯Yes ◯No	Scarlet Fever ◯Yes ◯No
Angina ◯Yes ◯No	Emphysema ◯Yes ◯No	High Blood Pressure ◯Yes ◯No	Shingles ◯Yes ◯No
Arthritis/Gout ◯Yes ◯No	Epilepsy or Seizures ◯Yes ◯No	Hives or Rash ◯Yes ◯No	Sickle Cell Disease ◯Yes ◯No
Artificial Heart Valve ◯Yes ◯No	Excessive Bleeding ◯Yes ◯No	Hypoglycemia ◯Yes ◯No	Sinus Trouble ◯Yes ◯No
Artificial Joint ◯Yes ◯No	Excessive Thirst ◯Yes ◯No	Irregular Heartbeat ◯Yes ◯No	Spina Bifida ◯Yes ◯No
Asthma ◯Yes ◯No	Fainting Spells/Dizziness ◯Yes ◯No	Kidney Problems ◯Yes ◯No	Stomach/Intestinal Disease ◯Yes ◯No
Blood Disease ◯Yes ◯No	Frequent Cough ◯Yes ◯No	Leukemia ◯Yes ◯No	Stroke ◯Yes ◯No
Blood Transfusion ◯Yes ◯No	Frequent Diarrhea ◯Yes ◯No	Liver Disease ◯Yes ◯No	Swelling of Limbs ◯Yes ◯No
Breathing Problem ◯Yes ◯No	Frequent Headaches ◯Yes ◯No	Low Blood Pressure ◯Yes ◯No	Thyroid Disease ◯Yes ◯No
Bruise Easily ◯Yes ◯No	Genital Herpes ◯Yes ◯No	Lung Disease ◯Yes ◯No	Tonsilitis ◯Yes ◯No
Cancer ◯Yes ◯No	Glaucoma ◯Yes ◯No	Mitral Valve Prolapse ◯Yes ◯No	Tuberculosis ◯Yes ◯No
Chemotherapy ◯Yes ◯No	Hay Fever ◯Yes ◯No	Pain in the Jaw Joints ◯Yes ◯No	Tumors or Growths ◯Yes ◯No
Chest Pains ◯Yes ◯No	Heart Attack/Failure ◯Yes ◯No	Parathyroid Disease ◯Yes ◯No	Ulcers ◯Yes ◯No
Cold Sores/Fever Blisters ◯Yes ◯No	Heart Murmur ◯Yes ◯No	Psychiatric Care ◯Yes ◯No	Venereal Disease ◯Yes ◯No
Congenital Heart Disorder ◯Yes ◯No	Heart Pace Maker ◯Yes ◯No	Radiation Treatments ◯Yes ◯No	Yellow Jaundice ◯Yes ◯No
Convulsions ◯Yes ◯No	Heart Trouble/Disease ◯Yes ◯No	Recent Weight Loss ◯Yes ◯No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Are you or have you ever taken any bisphosphonate medication (Boniva, Actonel, Fosamax, Zometa, etc.)? ◯ Yes ◯ No

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: _____ Date: _____

Signature of PARENT or GUARDIAN: _____ Date: _____

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Office Policies

In the interest of good health care practice and to keep our fees from rising, we have established a credit policy to avoid any misunderstanding. The benefits to a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

All accounts are due and payable at the time of your visit. Patients with insurance are expected to pay a portion of the treatment estimated on the day of dental service. Non-insured patients are expected to make payment in full on the day dental services are rendered unless definite arrangements have been made in advance. Cash, checks, Visa, Master Card, Discover, American Express and Care Credit are accepted. Up to 10% discount is extended to senior citizens (65 years and older) who have no insurance. Patients are liable for all fees connected with returned checks and processing. Appointments missed, without 24 hours notice will result in a $50 charge.

As a courtesy, our office will file your claim with your insurance and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow. We are only able to give an estimation of costs toward dental treatment and you are responsible for any costs not covered by insurance. We will assit you in obtaining your dental benefits that are specified in your dental contract by professionally accepted methods. Your insurance contract, however, is between you, your employer and the insurance company. It is important to understand that not all dental services are covered in all insurance contracts. Some insurance companies arbitrarily select certain services that they will not cover. It is your responsibility to determine your benefits with your plan. We will aid in the predetermination of your insurance benefits at your request. However, this will delay our ability to provide dental services to you as we wait for your insurance company to respond. After insurance payments have been received, if there is a balance on your account, our office will extend 30 days grace period for you to bring your account current. After the 30 days grace period any balance outstanding will bear interest at 18% per annum or 1.5% per month. These additional fees will be applied to the unpaid balance at the end of the month. We cannot accept responbility for collecting an insurance claim after 60 days or for negotiating a disputed claim, therefore, you are responsible for payments to your account. We will only send statements out to those accounts that have balances due. If we are waiting on your insurance payment, you may not receive a bill until we know accurately what insurance will cover.

I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payments on my account. I authorize Hillside Dental at Bethany to collect the payment owed if not paid within my account. I understand that my delinquent account will be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I understand and agree to pay for all costs and expenses including reasonable attorney fees. This will insure that our responsible patients will not be penalized to cover costs incurred by those who to not pay on time. All patients on an account that is referred to collections will only be eligible for emergency treatment for 30 days and will be dismissed from the dental practice if the balance is not paid.

I have read the above policies and agree to abide by them.

Signature of PATIENT, PARENT or GUARDIAN: _____ Date: _____

Agreement and Consent

1. I authorize and give consent to the doctor and the staff to administer treatment, including, but not limited to local anesthesia, analgesia, x-rays, photographs and any other treatment that in their judgment, may be necessary for dental health. I understand the use of medications, anesthetics and some procedures may embody a certain amount of risk. This may include allergic reactions and/or other reactions/sensitivities. If I am a female using oral contraceptives, I understand that antibiotics or other medications may interfere with the effectiveness of oral contraceptives. It is my responsibility to inform the doctor of any medical or dental conditions or concerns I may have.
2. During examination and treatment persons present in the operatory is limited to the doctor or hygienist (provider), assistant and patient.
3. I understand and agree that all photographs are the sole property of Hillside Dental at Bethany.
4. Dental treatment can be unpredictable. I acknowledge that no guarantee has been given as to the treatment results that may be obtained.
5. I consent to the proper disposal of any tissues or body parts that may be removed (i.e. tooth structure, mercury filling material, blood).
6. I acknowledge that the Notice of Privacy Practices is available and I have been given a copy.
7. I grant my permission to Hillside Dental at Bethany to contact me to discuss matters related to this consent, my treatment or my account.
8. I hereby authorize Hillside Dental at Bethany to release any information necessary to process my dental insurance claims. I further authorize a release of information if necessary to refer my case to a specialist.
9. I understand that responsibility for payment for dental services provided at Hillside Dental at Bethany for myself or my dependents is entirely mine, due and payable at the time services are rendered, unless other arrangements have been made. I understand deductables and copays are required at time of service. Any dishonored checks will be assessed a statutory handling and collection fee of $25 plus any bank related charges.
10. I hereby authorize and direct my insurance company to pay any dental benefits due to me directly to Hillside Dental at Bethany. I understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of this dental office.
11. I understand that appointment time is reserved specifically for me. It is my courtesy to provide 24 hours notice of any change in regards to scheduled dental appointments. Failure to provide this consideration will result in a $50 charge.

Signature of PATIENT, PARENT or GUARDIAN: _____ Date: _____

Print Patient Name: _____

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Receipt of the Notice of Privacy Practices

The Notice of Privacy Practices describes how my health information may be used and disclosed and how I can get access to this information.

I acknowledge that the Notice of Privacy Practices document has been provided to me.

Print Patient Name: _____

Signature of PATIENT, PARENT or GUARDIAN: _____ Date: _____