CENTRAL POINT FAMILY DENTISTRY
DR. NELSON
98 Freeman Road, Suite A, Central Point, OR 97502
(541) 664-8300 CentralPointFamilyDentistry.com

PATIENT NAME:_____ **DATE**_____

DENTAL QUESTIONNAIRE

1. **What is your #1 concern within your mouth?**

_____

2. **What would you change about your teeth?**

_____

3. **Date of your last dental exam/x-rays?** _____

Dental Concerns: Check all that apply:

- ☐ Cavities
- ☐ Dry Mouth
- ☐ Esthetics
- ☐ Gingiva (Gums)
- ☐ Infection/Abscess
- ☐ Jaw Discomfort
- ☐ Pain
- ☐ Sensitive teeth
- ☐ OTHER: _____

4. **How well do you feel you truly care for your teeth?**

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (1=Poor; 5=Ideal)

5. **What is your dental apprehension?**

☐ Low ☐ Medium ☐ Elevated

Dental Treatment Interested In:

- ☐ Braces
- ☐ Dentures/Partials
- ☐ Esthetics
- ☐ Extractions
- ☐ Fillings/Crowns
- ☐ Implants
- ☐ Preventing Cavities
- ☐ Teeth Whitening
- ☐ OTHER: _____

MEDICAL HISTORY

1. Health Conditions

YES

- ☐ Arthritis
- ☐ Alzheimer's or Dementia
- ☐ **Artificial Joint***†
- ☐ Attention Deficit or Autism
- ☐ Autoimmune (i.e. Lupus)
- ☐ Back Pains
- ☐ Blood Conditions
- ☐ Blood Pressure (High/Low)
- ☐ Cancer
- ☐ Chemo/Radiation
- ☐ **Diabetes**†
- ☐ Digestive Conditions
- ☐ **Glaucoma**†
- ☐ Head Injury
- ☐ **Heart Attack**†
- ☐ **Heart Condition***†
- ☐ Hepatitis A/B/C
- ☐ HIV†
- ☐ **Infective Endocarditis***†
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Psych (PTSD/Bipolar/Schizophrenia)
- ☐ Recreational Drug (i.e. Marijuana)
- ☐ Respiratory Conditions
- ☐ **Rheumatic Fever***†
- ☐ Seizures or Epilepsy
- ☐ **Stroke or TIA**†
- ☐ Thyroid Conditions
- ☐ Tobacco Use
- ☐ **Transplant***†
- ☐ **Tuberculosis**†
- ☐ Tumor or Growths
- ☐ OTHER: _____

* May need prophylactic antibiotics
†May need a medical consult from your MD/DO

2. Allergies

YES

- ☐ Anesthetics (i.e. lidocaine)
- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine/Shellfish
- ☐ Latex
- ☐ Metals (i.e. inexpensive jewelry)
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Tylenol
- ☐ OTHER: _____

3. Medications

YES

- ☐ **Bisphosphonates** (Actonel, Boniva, Fosamax, Zometa)
- ☐ **Blood Thinners** (Aspirin, Coumadin, Warfarin)
- ☐ **Diet Pills** (Phen-fen, Pondimin, Redux, etc.)
- ☐ **Steroids** (Prednisone, Cortisone, etc.)

List Medications taking:

_____

_____

_____

_____

_____

_____

4. Women Only

YES

- ☐ I am taking birth control pills
- ☐ I am nursing
- ☐ I may be pregnant.

Due date: _____

5. Medical Physician Info

Physician Name: _____

Physician Phone: _____

Updated Medical Info

ONLY FILL OUT WHEN UPDATING MEDICAL HISTORY FORM

List any changes to your medical history and confirming all medical is correct:

_____

_____

_____

_____

Patient Signature **Date**

Dr Signature **Date**

Patient Signature: _____ **Date:** _____ **Dentist Signature:** _____

CENTRAL POINT FAMILY DENTISTRY
DR. STEVE NELSON

98 Freeman Rd, Suite A, Central Point 97502
(541) 664-8300 CentralPointFamilyDentistry.com

REGISTRATION FORM

CONFIDENTIAL PATIENT INFORMATION

Preferred First Name:				Today's Date:	
Patient's Last Name: First: Initial:			❑ Minor ❑ Dependent	**M F**	**Marital Status (circle one)** Single Married
Phone:(circle) C H W ( )	Second Phone: C H W ( )	SSN #:		Age:	Date of Birth:
Street Address:		Email address:			
City:	State/ Zip Code:	Preferred way to be notified of appts: Phone Text Email			Cell Phone Carrier:
If Married, Name of Spouse:		If a minor/dependent, names of both **legal guardians**: Name:		Relation to the patient:	
Spouse's Phone:		Name:		Relation to the patient:	

How did you hear about us? ❑ Friend ❑ Internet ❑Location ❑ ValPak ❑ Website ❑Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person Responsible for Bill:	Phone Number: ( )	Address (if different from above):		Employer:

Please indicate **PRIMARY** Dental insurance:

❑ Delta (ODS/MODA Premier) ❑ Cigna ❑ Other (specify) _____

Subscriber's Name:	Subscriber's SSN:	Birth date:	Group number:	Policy no.:

Patient's relationship to subscriber: Self Spouse Child Other

SECONDARY Insurance (if applicable):	Subscriber's name:	Group Number	Policy Number:

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of a relative or local friend:	Relationship to patient:	Primary Phone: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize my insurance benefits be paid directly to this dental office and authorize **CPFD** to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

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.

We are required by law to maintain the privacy of protected health information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. We must follow the privacy practices that are described in this Notice. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all PHI that we maintain. When we make a significant change in our privacy practices we will provide copies of the new Notice upon request. You may request a copy of our Notice at any time. For more

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. Some information, such as HIV-related or genetic info, alcohol and/or substance-use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these protections as they pertain to cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. We may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. I.e. we may send claims to your dental health plan containing certain health information.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends, or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to: • Prevent or control disease, injury or disability • Report child abuse or neglect • Report reactions to medications or problems with products or devices• Notify a person of a recall, repair, or replacement of products or devices • Notify a person who may have been exposed to a disease or condition• Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 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 PHI of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order, or when required by law.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable their duties.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program"), we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may also request access by sending us a letter to the address at the end of this Notice. We will send you what is specifically requested. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request to our office in writing. If you request this accounting more than once in a 12-month period, we may charge you a cost-based fee to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be made under the alternative means. We will accommodate all reasonable requests. However, if we are unable to contact you using the new way you have requested, we may contact you using the info we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured PHI as required by law.

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or if 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 in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

INSURANCE & COSTS Payment is expected by the time of service. Our fees may be different than what insurance covers. Insurance reimbursements may be less, the same, or more than our private practice fees. Any balance not paid by insurance is the responsibility of the patient or guardian. Returned checks are subject to a $25 fee per check. I understand and accept the responsibility of payment due and payable at the time service for dental services, therapeutics, or devices provided in this office for my dependents or myself. I will keep my commitment to these financial arrangements. I agree that if I become delinquent over 30 days on any arrangements, the remaining charges will become immediately due and payable in full. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 20 days of the billing date. I further understand and agree that up to 1½% per month (18% ANNUAL) finance charge may be added to any balance for which no payment has been made over 60 days. If sent to collections, there is a fee to cover those expenses. In the event of default on my part to pay the charges, I (we) promise to pay legal interest on indebtedness, together with such collection costs, reasonable attorney fees, and other reasonable expenses incurred by Dr. Nelson as may be required to effect collection of this debt. I authorized payment directly to Dr. Nelson of any benefits otherwise payable to me from my insurance company or dental benefit plan.

TREATMENT CONSENT The undersigned hereby authorizes Doctor Nelson and his authorized employees to take radiographs, study models, photographs, perform or order tests, or any other diagnostic aids deemed necessary or appropriate by Dr. Nelson to make a thorough diagnosis of the oral and physical condition of the patient. I give permission for any photos taken of my case may be used for marketing so long that HIPAA is followed. I also authorize Dr. Nelson to perform any and all forms of treatment, medication, and/or therapy that may be indicated in connection with treating the disease conditions. I understand that the use of anesthetic agents embodies certain risks, which I accept if I choose to use anesthesia. I will not hold Dr. Nelson or his staff responsible for any omission or incomplete medical or dental history forms. I understand that there are no guarantees or warranties of any kind stated or implied by Dr. Nelson or his staff in reference to any treatment they render. In the event of a dispute of treatment, I agree to abide by the decision of an arbiter agreeable by Dr. Nelson and me. I agree to pay all the arbitration process costs and submit to this process before complaining to the Oregon State Board of Dentistry.

APPOINTMENTS Once an appointment is confirmed, please remember that the time and resources have been reserved exclusively for you. If you fail to show or cancel without 48-hours' notice, a minimum charge of $50 may be assessed. We will be lenient on the first incident and will consider your reasons. This charge is based on time reserved for your appointment and covers lost overhead expenses of this office such as the salaries, utilities, rent, etc. We take very seriously your time and try our best to respect it, and in return we ask the same courtesy and consideration. I agree with my signature to all the above conditions as set forth. A photocopy of this document shall be as valid as the original.

I authorize the following family member or representative to discuss patient's dental care treatment with the Central Point Family Dentistry. This person can make final treatment and financial decisions with, and, or for the patient:

NAME(S) OF THOSE GIVEN CONSENT:_____

Patient Name	**Signature (of patient or guardian)**	**Date**