CENTRAL POINT FAMILY DENTISTRY
DR. STEVE NELSON
1333 Plaza Blvd, 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/or sign all medical is correct:

_____
_____
_____
_____
_____

Sign **Date**

Sign **Date**

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

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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*

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DENTAL CONSENTS

HIPAA

The Department of Health and Human Services has established a "Privacy Rule" to help assure that personal health care information is protected for privacy. This rule was also created to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of personal health information (PHI) about the patient to carry out treatment, payment, or health care operations. We respect the privacy of your health care records and will do all we can to secure the privacy of that information. When it is appropriate and necessary, we provide the minimum PHI information about treatment, payment, or health care operations to essential indirect parties like labs, insurance companies, etc. You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. You may not revoke actions that have already been taken, which relied on this previously signed consent. You also have the right to review our privacy notice, to request restrictions, and to revoke your consent in writing after signing this notice. We support your full access to your personal health records.

INSURANCE & COSTS

Payment is expected by the time of service. Our fees may be different than what insurance covers. At times 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 commitments for 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 for over 60 days. If sent to collections, there is around a $35 charge to cover those expenses. In the event of default on my part to pay the charges, I (we) promise to pay legal interest on the indebtedness, together with such collection costs, reasonable attorney's fees, and other reasonable expenses incurred by Dr. Nelson as may be required to effect collection of this debt. I also 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 and no personal information is linked to those photos. 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.

I also consent and authorize Dr. Nelson to release any and all information about my dental condition and treatments to my insurance company as may be required to obtain benefits from them. 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. These expenses must be paid whether or not you are present. 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 friend to discuss patient's dental care treatment and finances with the Central Point Family Dentistry dental team, and can make final treatment decisions with and/or for the patient:

NAME OF THOSE GIVEN CONSENT: _____

PATIENT or GUARDIAN SIGNATURE: _____

PATIENT NAME: _____ DATE _____