Warm Springs Dental

Modern Comfortable Care

Jessica Ellis, D.D.S. Bryan Euzent, D.D.S.

Patient Information

First Name:______________________ **Last Name**:______________________ **Middle Initial**:_____

Patient is: ☐ Policy Holder **Preferred Name:**__________________ **SS#:**______________

☐ Responsible Party

Address:__________________________________ Address 2:__________________________

City: ______________________ State:__________ Zip Code:______________

Home Phone: ______________ Work Phone:______________ Ext:_____ Cell Phone:______________

Birthdate: ______________ E-mail:__________________ ☐ I would like to receive correspondence via e-mail

Sex: ○ Male ○ Female

Name of Employer:_______________________ School:__________________________

Referred by:_______________________ Person to Contact in Case of Emergency:__________________

Emergency Contact #s:__________________________

Responsible Party (if someone other than the patient)

First Name:______________________ Last Name:______________________ Middle Initial:_____

Address:______________________________ Address 2:__________________________

City: ______________________ State:__________ Zip Code:______________

Home Phone: ______________ Work Phone:______________ Ext:_____ Cell Phone:______________

Birthdate: __________________ Relationship to Patient:____________________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured:____________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Company:__________________ Insured Employer:__________________________

Insured SS# or Carrier ID#:__________________ Group#:__________ Insured Birthdate:____________

Secondary Insurance Information

Name of Insured:____________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Company:__________________ Insured Employer:__________________________

Insured SS# or Carrier ID#:__________________ Group#:__________ Insured Birthdate:____________

Authorization

I hereby authorize payment directly to Warm Springs Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Warm Springs Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X______________________________ ______________

Patient or Responsible Party Date

Service Charge

If I do not pay the entire new balance within 20 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.8% per month (or a minimum charge of $5.00 for a balance under $100.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Patient or responsible party may be subject to a **$75 per hour failed appointment fee** if the appointment is broken without 24 hour notice.

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DENTAL HEALTH QUESTIONNAIRE

1. **Name of previous Dentist**:____a
2. **How long since your last dental cleaning**?_________________________________
3. **What brought you into our office today**? ______________________________aa
4. **Have you had any of the following experiences:**

□ Bleeding gums
□ Diagnosed with gum disease
□ Bad breath or bad taste in mouth
□ Braces or orthodontia
□ Acid Reflux
□ Accident/injury involving head or neck
□ Grinding teeth
□ Night Guard use
□ Clicking or popping in jaw
□ Headaches or migraines
□ Sensitivity to hot and cold
□ Sleep Apnea/snoring

5. **If you could change anything about your smile which of the following would you want to change?**

□ Whiter
□ Replace chipped teeth
□ Replace old crowns
□ Remove silver fillings
□ Less gums showing
□ Close spaces
□ Replace missing teeth
□ Straighter
□ Remove stains or spots on teeth
□ Resize/ reshape my teeth

"""""""""" ***I would like to have a complimentary smile analysis.***

6. **Which are important to you when making your dental health decisions:**

""""""""""□ Conveniencg
""""""""""□ Relationship with dental team
""""""""""□ Time
""""""""""□ What insurance covers
""""""""""□ Detailed treatment explanations
""""""""""□ Comfort
□ Appearance
□ Finances
□ Quality of care
□ Health
□ Fear or Anxiety
□ Technology

7. **Is there anything else you would like us to know about your dental history?**""""

""""""""""____
""""""""""____
""""""""""____
""""""""""____

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Patient Name: Birth Date:

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.

Question	Yes / No	If yes
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco? Type and frequency?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ None

Other Allergies? ◯ Yes ◯ No If yes

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

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Herpes Simplex Virus	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina/Chest Pain	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	HIV Positive/AIDS	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Fainting/Dizziness	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Irregular Heart Beat	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Frequent Head Aches	◯ Yes ◯ No	Kidney Problems/Dialysis	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	GERD/Acid Reflux	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Bruise/Bleed Easily	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Liver Problems	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Tonsilitis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disease	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No		

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

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 current or future changes in medical status.

Signature of Patient, Parent or Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive/review a copy of Warm Springs Dental's Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have been given the opportunity to receive/review this organization's Notice of our Privacy Practices.

______________________________________ Patient Name (Type or Print)

______________________________________ Patient's Date of Birth

______________________________________ Signature of Patient or Parent/Legal Guardian

______________________________________ Date Signed

______________________________________ Name of parent/legal guardian if signing for patient

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify): ______________________________________

Notes: ______________________________________

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Important Dental Insurance Information

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage that fits the company budget. Each plan is slightly different regarding its covered services.

Our office is currently a **Premier** provider with ODS/Moda/Delta Dental. If your plan requires you to see a preferred provider and you do not have the insurance company listed above, we are still excited to see you. We recommend that you check with your insurance company regarding your available benefits in our office and encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

- Filing your insurance within 24 hours of your visit and requesting payment of your insurance benefits to our office.
- Electronically filing your insurance for short turnaround.
- Submission of paid claims to a secondary insurance
- Re-filing your insurance a second time within 30 days.
- Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

- Co-payments not covered by your insurance plan are paid at time of services, unless specific payment arrangements have been made.
- To understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
- To recognize that dental insurance policies restrict payment for some services, use restricted fee schedules (called "Usual and Customary Rates"), and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on policy limitation, not our fees or recommended treatment.
- To take responsibility for payment if the insurance company does not pay our office within **90 days.**
- If you have dual coverage, please check to see if your insurance has a **non-duplication of benefits clause**. If it does, please become familiar with the restrictions. You may receive a **reduced benefit** from your secondary insurance. (We do not bill tertiary insurance)
- To keep our office informed of any changes in your insurance coverage or employment.

We are always happy to help maximize your insurance benefits and answer any questions you may have. Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

*I hereby authorize Warm Springs Dental to release to my insurance company any information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Warm Springs Dental. I understand that estimates given to me by Warm Springs Dental regarding my insurance are **not a guarantee of payment**. I am responsible for any unpaid balance after my insurance pays.*

X____ X____________________

Signature of Patient/Guardian **Date**

8220 SW Warm Springs Street, Suite #200, Tualatin, OR 97062
Phone: (503) 692-0337 • Fax: (503) 692-0792
www.WarmSpringsDental.com

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

WARM SPRINGS DENTAL

Persons to Whom Information May Be Disclosed:

[ ] *Decline authorization to all persons*

[ ] Spouse: ___________________________ [ ] Parent(s):___________________________

[ ] Children: __________________________ [ ] Other: _____________________________

Information to be Used or Disclosed
The information covered by this authorization includes:

[ ] Treatment rendered to me [ ] Diagnosis [ ] Records

[ ] Account Information [ ] Appointment Information

Persons Authorized to Use or Disclose the Above Information: WARM SPRINGS DENTAL

Expiration Date of Authorization
This authorization is effective through date (check one) ❑_______________ or ❑ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

____
Name of Patient (Type/Print)

____
Signature of Patient Date

____
Signature of Patient Representative (if applicable)

____
Relationship of Patient Representative to Patient (if applicable)