New Patient Adult Packet

PATIENT INFORMATION

First Name: Last Name: DOB: SSN:

Email: Occupation Marital Status:

Spouse Name: (if on insurance) Spouse Birth Date: (if on insurance)

Whom may we thank for referring you?

DENTAL INSURANCE AND/OR ACCOUNT RESPONSIBILITY

Who is the main subscriber on this policy? Insurance company:

Member ID #: Relationship to patient: Insurance company claims address (located on back of insurance card):

Is patient covered by an additional insurance?

- ○ Yes
- ○ No

Subscriber's Name:

Birthdate: Insurance company:

Member ID #: Relationship to Patient: Insurance company claims address (located on back of insurance card):

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with

And assign directly to treating doctor 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

PHONE NUMBERS

Home Phone: Cell Phone:

Do you prefer to be contacted by: (circle one)

- ○ Email
- ○ Text
- ○ Phone

Emergency Contact Name: Relationship: Phone:

Today's Date:

Preferred Name:

- ○ Miss
- ○ Mr.
- ○ Mrs.
- ○ Ms.
- ○ Dr.

Mailing address: | City: | State: | Zip:

Sex:

- ○ Male
- ○ Female

Dental Information

For the following questions, mark (x) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	○	○	○
Are your teeth sensitive to col d, hot, sweets or pressure?	○	○	○
Is your mouth dry?	○	○	○
Have you had any periodontal (gum) treatments?	○	○	○
Have you ever had orthodontic (braces) treatments?	○	○	○
Have you had any problems a ssociated with previous denta l treatment?	○	○	○
Is your home water supply flu oridated?	○	○	○
Are you currently experiencing dental pain or discomfort?	○	○	○
Do you have earaches or neck pains?	○	○	○
Do you have any clicking, pop ping or discomfort in the jaw?	○	○	○
Do you brux or grind your teet h?	○	○	○
Do you have sores or ulcers in your mouth?	○	○	○
Do you wear dentures or parti als?	○	○	○
Do you participate in active re creational activities?	○	○	○
Have you ever had a serious in jury to your head or mouth?	○	○	○

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems. (Check DK if you Don't Know the answer to the question)

Are you now under the care of a physician?

- ○ Yes
- ○ No
- ○ DK

Physician Name: _____ Phone: _____

If yes, what condition was treated?

_____

	Yes	No	DK
Are you in good health?	○	○	○
Has there been any change in your general health within the past year?	○	○	○

Date of last physical exam:

_____

	Yes	No	DK
Do you wear contact lenses?	○	○	○
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	○	○	○
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	○	○	○
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	○	○	○

Have you had a serious illness, operation or been hospitalized in the past 5 years?

- ○ Yes
- ○ No
- ○ DK

If yes, what was the illness or problem?

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)?

- ○ Yes
- ○ No
- ○ DK

If so, please list all, including vitamins, natural or herbal preparations and/ or diet supplements:

Do you use controlled substances (drugs)?

- ○ Yes
- ○ No
- ○ DK

Do you use tobacco (smoking, snuff, chew, bidis)?

- ○ Yes
- ○ No
- ○ DK

if so, how interested are you in stopping?

- ○ VERY
- ○ SOMEWHAT
- ○ NOT INTERESTED

Do you drink alcoholic beverages?

- ○ Yes
- ○ No
- ○ DK

If yes, how much alcohol did drink in the last 24 hours?

_____

If yes, how much do you typically drink in a week?

_____

WOMEN ONLY Are you:

Pregnant?

- ○ Yes
- ○ No
- ○ DK

Number of weeks:

_____

Taking birth control pills or hormone replacement?

- ○ Yes
- ○ No
- ○ DK

Nursing?

- ○ Yes
- ○ No
- ○ DK

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?

- ○ Yes
- ○ No
- ○ DK

Date:

_____

If yes, have you had any complications?

_____

Allergies - Are you allergic to, or have you had a reaction to:

To all yes responses, specify type of reaction.

Local anesthetics
- ○ Yes
- ○ No
- ○ DK

Aspirin
- ○ Yes
- ○ No
- ○ DK

Penicillin or other antibiotics
- ○ Yes
- ○ No
- ○ DK

Barbiturates, sedatives, or sleeping pills
- ○ Yes
- ○ No
- ○ DK

Sulfa drugs
- ○ Yes
- ○ No
- ○ DK

Codeine or other narcotics
- ○ Yes
- ○ No
- ○ DK

Metal
- ○ Yes
- ○ No
- ○ DK

Latex
- ○ Yes
- ○ No
- ○ DK

Iodine
- ○ Yes
- ○ No
- ○ DK

Hey Fever/seasonal
- ○ Yes
- ○ No
- ○ DK

Animals
- ○ Yes
- ○ No
- ○ DK

Food
- ○ Yes
- ○ No
- ○ DK

Other
- ○ Yes
- ○ No
- ○ DK

Problems

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back problems
- ☐ Bleeding problems
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cancer - Chemotherapy
- ☐ Chest Pains
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV - AIDS
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sinus Trouble
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

- ☐ Blood transfusion
- ☐ Cardiovascular disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Damaged heart valves
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosus
- ☐ Malnutrition
- ☐ Gastrointestinal disease
- ☐ GE. Reflux/Persistent heartburn
- ☐ Glaucoma
- ☐ Rheumatic heart disease
- ☐ Persistent swollen glands in neck
- ☐ Severe headaches/ Migraines
- ☐ Severe of rapid weight loss
- ☐ Excessive urination
- ☐ Sexually transmitted disease
- ☐ jaundice or Severe headaches

☐ Blood Transfusion

If Yes, Date:

☐ Neurological disorders

If Yes, Specify:

☐ Mental health disorders

If Yes, Specify:

☐ Recurrent infections

Type of infection:

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
- ○ Yes
- ○ No

Name of physician or dentist making recommendation:

Phone: ( )

○ DK

Do you have any disease, condition, or problem not listed above that you think I should Know about?

Please explain:

○ Yes

○ No

○ DK

NOTE:

Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

GENERAL CONSENT FOR TREATMENT

I,

_____

understand that this treatment plan is based on the current knowledge of my clinical conditions. I understand that during the course of treatment clinical conditions may change necessitating a change in the treatment plan and that I will be fully informed of any changes. I have been provided an opportunity to ask any questions regarding my treatment including the risks and benefits of care or not receiving care and I have had them addressed satisfactorily. I understand that some of my dental needs cannot be treated at this office and that those items have been identified. I further understand that this treatment plan and estimate has been created without considering insurance limits and deductibles, as these amounts may change prior to the completion of treatment. The patient's estimated amounts have not been verified with my insurance carrier. The total cost of treatment is my responsibility. Estimated patient amounts, co-pays, and deductibles must be paid on the date of service, unless alternate arrangements have been made prior to treatment. An insurance claim will then be submitted to my insurance carrier. When payments are received from the insurance carrier any amounts not covered will be billed to me and I will receive a statement. I have read, understand and now give my permission for treatment at Dedicated Dentistry for myself or the minor patient named above.

OFFICE POLICIES

Welcome to the office of Tavi Henry D.D.S, P.C. We feel it is important to inform you of our policies prior to you seeing the Doctor. We will bill all insurance claims as a courtesy to our patients. Any claims not paid by insurance within 90 days will be turned over to patient for reimbursement. The ultimate responsibility for payment of charges is the patient’s, regardless of the type of insurance a patient has. Insurance reimbursement is a contract between the patient and the insurance carrier. We request you pay your copay and non-covered charges at the time of service unless previous arrangements have been made. We accept cash, checks, Visa, MasterCard, American Express and Discover. Any balances not paid by insurance will be assessed an interest charge after 60 days. Any delinquent accounts older than 90 days will be turned over to collection. Once a patient is sent to collections, they will be asked to choose another Dentist. We will attempt to give our patients a reminder call the business day prior to their appointment. We request that if you have to change your appointment you do so 24 hours in advance as a courtesy to us and other patients who want to be seen. Leaving a message on the answering service does not constitute notice when we do not have time to fill the appointment. Patients who do not cancel or reschedule at least 24 hours in advance will be charged $45/hour scheduled, there will also be a $45 charge for patient who no-show for an appointment. Patient who no-show or cancel 3 times will be asked to seek care elsewhere. Patient's requesting a copy of their records must do so in writing. There will be a nominal charge to copy the records, based on the size of the patient's file. Patients will be seen for the type of treatment and diagnostic appointment scheduled only. If additional treatment and/or diagnostics are required, the patient may be requested to return for another visit. We ask that all paperwork required be filled out prior to seeing the Doctor. The patient must have a current ID card complete with claim mailing address. Please verify that Dr. Henry is listed as a provider of that you are able to go out of network. If Dr. Henry is not listed as a provider, the patient is responsible for payment at the time of service. IT |S THE PATIENT’S RESPONSIBILITY TO KNOW THEIR INSURANCE BENEFITS

TRUTH IN LENDING EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES

Annual Percentage Rate (APR) for Purchases

15.00%

Paying Interest

A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.

Minimum Interest

If you are charged interest, the charge will be no less than $1.00

FEES

Late Charge

$1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00

Non-Sufficient Funds (NSF) Fee

$25.00 per payment

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information: - Your name and account number. - The dollar amount of the suspected error. - Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct. - After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. - If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn’t make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due. - If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report to that it has been settled. - If we don’t follow these rules, we can’t collect the first $50.00 of the questioned amount even if your bill was correct. - Your continued use of this account constitutes your acceptance of the above stated conditions. - I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity

Dental Entity Name:

AASM - Risk of OSA (Obstructive Sleep Apnea)

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

- ☐ Have you ever been diagnosed with a sleep disorder?
- ☐ Are you currently using a CPAP machine?
- ☐ Do you use it every night?

	Yes	No
8 Have you ever been told you stop breathing while a sleep?	○	○
6 Have you ever fallen asleep or nodded off while driving?	○	○
6 Have you ever woken up sud denly with shortness of breat h, gasping or with your heart r acing?	○	○
4 Do you feel excessively slee py during the day?	○	○
4 Do you snore, or have you ev er been told that you snore?	○	○
2 Have you had weight gain an d found it difficult to lose?	○	○
2 Have you taken medication f or, or been diagnosed with hig h blood pressure?	○	○
3 Do you kick or jerk your legs while sleeping?	○	○
3 Do you feel burning, tingling or crawling sensations in your legs when you wake up?	○	○
3 Do you wake up with heada	○	○

ches during the night or in the morning?		
4 Do you have trouble falling a sleep?	○	○
4 Do you have trouble staying asleep once you fall asleep?	○	○

Total Score and Risk Factor:

Low 0-7 Moderate 8-11 High 12-15 Savere 16+

Signature:

Sign