PATIENT INFORMATION

Name _____
Last First Middle Initial

Gender: □ Male □ Female Marital Status: □ Married □ Single □ Other_____

Address _____
Street City State Zip Code

Social Security # _____-_____-_____Date of Birth ____/____/____Email_____

Home Phone_____ □ Not okay to leave message with detailed information.

Cell Phone_____ □ Not okay to leave message with detailed information.

Employer _____ Occupation_____

In case of emergency, who should we notify? _____ Phone_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name _____ Phone_____ Group/Policy #_____

Insured's Name _____ Insured's Date of Birth_____ Relation_____

Insured's SSN/ID #_____ Insured's Employer Name_____

Secondary Insurance

Insurance Co. Name _____ Phone_____ Group/Policy #_____

Insured's Name _____ Insured's Date of Birth_____ Relation_____

Insured's SSN/ID #_____ Insured's Employer Name_____

Physician's name _____Phone_____

Previous Dentist _____Phone_____

Person responsible for payment (Name) _____Relation_____

How did you hear about our Office? (please check only one)

❑ Friend/Relative ❑ Insurance Plan ❑ Internet ❑ Newspaper ❑ Other

If you were referred, whom may we thank for referring you? _____

PATIENT AGREEMENT

- □ I authorize Pacific Dental Care, P.C. to verify and release any medical or dental information to process my insurance claims.
- □ I agree to inform Pacific Dental Care, P.C. of any changes in my home address, phone number, or insurance coverage.
- □ I understand that I am fully responsible to give the most accurate information regarding my insurance, medical or dental status. I accept responsibility for any unpaid balances do to a denial of claims as a result of inaccurate information provided.
- □ Deductible and co-pay are expected at time of service unless prior arrangement was made. A **$50** will be charged for check return due to insufficient funds.
- □ I was informed about the "no-shows or within-24-hours cancellation" policy. Violation of this policy will result in a **charge of $30 per an appointment** or **discontinuation of service**. For OHP patients, discontinuation status will be reported to ODS or CDC. This may result in a disqualification in my future coverage.
- □ I am aware not all dental procedure is covered by OHP (Oregon Health Plan) dental insurance. Therefore, our office will not perform those procedures for patients who have OHP, unless I sign a wavier to be financially responsible for those non-covered procedures/services.
- □ While Pacific Dental Care, P.C. will attempt to contact me for appointment confirmation, it is my responsibility to call to confirm, or cancel, the appointment 24 hours in advance.
- □ We require 2-4 weeks to process any request or concern according to patient treatment(s).
- □ I acknowledge this office Notice of Privacy Practices and understand it.

_____ _____/_____/_____

Patient's (or Guardian) Signature **Date**

DENTAL HISTORY

Do you presently have or have you had: (Please check YES or NO for the following)

Yes □ No □ Are you currently experiencing pain or discomfort in the mouth, face, or jaw?
Yes □ No □ Do your gums bleed when you brush or floss?
Yes □ No □ Are your teeth sensitive to cold, hot, sweets, sour or pressure?
Yes □ No □ Have you had any head, neck, or jaw injuries?
Yes □ No □ Have you ever had Oral surgery? If yes, please explain. _____
Yes □ No □ Have you had any dental implants placed?
Yes □ No □ Have you ever had orthodontic (braces) treatment?
Yes □ No □ Do you wear removable dental appliances?
Yes □ No □ Have you had serious trouble associated with any previous dental treatment?
Date of last dental treatment: _____/_____/_____
Reason or concern for today's visit: _____

MEDICAL HISTORY

Yes □ No □ Are you in good health?
Yes □ No □ Have you been hospitalized or had any surgeries?
If YES, please explain. _____
Yes □ No □ Have you been under treatment of a medical doctor?
If yes, what was the illness or problem? _____
Yes □ No □ Are you currently taking, or have you taken any medications or herbals within the past two years?
Please check those that apply:

___Digitalis or heart medication
___Blood pressure pills
___Seizure medications
___Insulin (shots)
___Diabetic pills
___Blood thinner (Coumadin/Wafarin)
___Asthmas or emphysema meds
___Ulcer medications
___Sedatives
___Other _____

___Aspirin, Bufferin, Empirin
___Tranquilizers
___Antibiotics
___Antihistamines
___Vitamins
___Pain pills
___Glaucoma medicine
___Hormones or birth control pills
___Antidepressants

___Antacids (Maalox, Tums)
___Laxatives
___Arthritis medicine
___Thyroid Hormone
___Steroids (Prednisone)
___Osteoporosis medication (Fosamax, Actonel, Bonvia)
___Erectile Dysfunction (Viagra, Cialis, Levitra)

Yes □ No □ Have you ever had prolonged bleeding?
Yes □ No □ Are you allergic to any medications or substances? If yes, please check box below:
□LIDOCAIN □MEPIVACAIN □PENICILLIN □CODEIN □ASPIRIN □SULFA □LATEX
□Other _____
Yes □ No □ Do you have chest pain or exertion?
Yes □ No □ Have you ever had painful or swollen joint?
Yes □ No □ Do you use tobacco product? _____ Alcohol? _____
Yes □ No □ Have you ever had any of the following? Please check those that apply:

___High blood pressure
___Heart disease, Heart Murmur
___Rheumatic fever
___Artificial heart valve
___Artificial joint
___Pacemaker
___Anemia
___Sleep apnea
___Breast Cancer Treatment
___Other _____

___Thyroid disease
___Kidney disease
___Hemophilia
___Mental illness
___Cancer, Leukemia
___Tuberculosis
___Ulcer
___Nervousness/anxiety
___Immune suppression

___Diabetes (Type I/II)
___Venereal disease (Syphilis, Gonorrhea)
___Asthma
___Hepatitis:_____
___Epilepsy
___AIDS or HIV
___Radiation therapy
___Osteoporosis

(**WOMEN ONLY**) Are you pregnant? □ Yes □ No Due Date: _____ Nursing: □ Yes □ No

_____ _____/_____/_____
Dr/Hyg. Signature Date