Welcome to Smile Oswego Dental! We are so happy to have you here!

Today's Date: _____

Patient Information

Patient Name: _____
Last Name First Name Middle

Preferred Name: _____ Family Status: ☐Single ☐Married ☐Child ☐Other

Mailing Address: _____
Street Apt/Unit# City State Zip

Patient Birthdate: _____ Social Security # (If patient is over 18yrs old) : _____ Sex: M ☐ F ☐

Driver's License or State ID#: _____ Email Address: _____

Primary Phone #: _____ Home ☐ Cell ☐ Work ☐ Secondary Phone #: _____ Home ☐ Cell ☐ Work ☐

How did you hear about our office? (If referred by another patient, please tell us their name so we can thank them): _____

Responsible Party/Guardian Information

*If this information is the same as above you may skip the next 4 lines and continue at the *Employer information section.

Name: _____ Birthdate: _____
Last Name First Name Middle

Social Security #: _____ Relationship to Patient: _____ Sex: M ☐ F ☐

Mailing Address: _____
Street Apt/Unit# City State Zip

Primary Phone #: _____ Home ☐ Cell ☐ Work ☐ Secondary Phone #: _____ Home ☐ Cell ☐ Work ☐

*Employer: _____ Occupation: _____ # Years Employed: _____

Spouse Name: _____ Birthdate: _____ SS #: _____
Last First Middle

Spouse Primary Phone #: _____ HM ☐ Cell ☐ WRK ☐ Spouse Secondary Phone #: _____ HM ☐ Cell ☐ WRK ☐

Spouse Employer: _____ Occupation: _____ # Years Employed: _____

Dental Insurance Information

Subscriber Name: _____ Subscriber ID or SS #: _____

Subscriber DOB: _____ Insur Co. Name: _____ Insur Phone #: _____ Group #: _____

Subscriber Address (if different from patient): _____ Subscriber Employer: _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Secondary Subscriber Name: _____ ID or SS #: _____ Subscriber DOB: _____

Subscriber Address (if different from patient): _____ Subscriber Employer: _____

2nd Insurance Co. Name: _____ 2nd Insurance Phone #: _____ Group #: _____

Emergency Contact Information

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Medical Health

What would you consider your general health to be? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Primary Care Physician Name: _____ Physician Phone #: _____

Are you taking any medication? Yes ☐ No ☐ If Yes, Please List Below:

Medication: _____ For what purpose? _____

Medication: _____ For what purpose? _____

Medication: _____ For what purpose? _____

Medication: _____ For what purpose? _____

Do you have OR have you ever had the following medical conditions:

Abnormal Blood Pressure: High/Low	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐
Abnormal Bleeding	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐
AFib	Yes ☐ No ☐	Heart Surgery	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Hepatitis Type_____	Yes ☐ No ☐
Angina (Chest Pain)	Yes ☐ No ☐	HIV+/AIDS	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Kidney Disease/Problems	Yes ☐ No ☐
Artificial Heart Valves	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Artificial Bones/Joints	Yes ☐ No ☐	Lung Disease/COPD	Yes ☐ No ☐
Asthma/Difficulty Breathing	Yes ☐ No ☐	Mental Disability	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Mental Illness	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐
Chemotherapy or Radiation Treatment	Yes ☐ No ☐	Organ Transplant	Yes ☐ No ☐
Colitis/Ulcers	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Congenital Heart Defect	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐
Dementia/Alzheimer's Disease	Yes ☐ No ☐	Rheumatic Fever/Scarlet Fever	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Steroid Therapy	Yes ☐ No ☐
Epilepsy/Seizures	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Frequent/Severe Headaches	Yes ☐ No ☐	Substance Abuse Problems	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Hay Fever/Sinus Trouble	Yes ☐ No ☐	Tuberculosis (TB)	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Tumors	Yes ☐ No ☐

Are you allergic to: Penicillin:☐ Codeine:☐ Sulfa Drugs:☐ Erythromycin:☐ Dental Anesthetics:☐ Iodine:☐ Metals/Nickel:☐
Aspirin:☐ Ibuprofen:☐ Latex/Plastics:☐ Barbiturates:☐ Any Other Medications/Materials? _____

Do you take antibiotics prior to dental treatment? Yes ☐ No ☐ Are you taking any blood thinners? Yes ☐ No ☐

Are you subject to prolonged bleeding? Yes ☐ No ☐ Are you subject to fainting spells? Yes ☐ No ☐

Do you have excessive urination and/or thirst? Yes ☐ No ☐ Do you use tobacco products? Yes ☐ No ☐

Have you ever had or are you currently getting IV Zoledronic Acid Treatments (such as Zometa or Reclast)? Yes ☐ No ☐

Please list any Major Surgeries: Year: _____ Type of Surgery: _____ Year: _____ Type of Surgery: _____

If you have any other medical problems not listed please explain: _____

Women: Are you or could you be pregnant? Yes ☐ No ☐ If yes, expected due date? _____ Are you nursing? Yes ☐ No ☐

Dental Health: Previous Dentist's Name _____ Previous Dentist's Phone #: _____

Reason for your visit today: _____ When was your last dental visit? _____

Have you ever experienced problems associated with previous dental treatment? Yes ☐ No ☐ Explain: _____

Are you experiencing any tooth, mouth, or jaw pain? Yes ☐ No ☐ Explain: _____

Are your teeth sensitive to hot, cold, or anything else? Yes ☐ No ☐ Explain: _____

How often do you brush your teeth? _____ How often do you floss? _____

Type of bristles on your toothbrush? Soft ☐ Medium ☐ Hard ☐ Do you use an electric toothbrush and/or WaterPik? Yes ☐ No ☐

Do your gums bleed when brushing? Yes ☐ No ☐ Do your gums bleed when flossing? Yes ☐ No ☐

Do you use a Night Guard? Yes ☐ No ☐ Do you use a Sleep Apnea Device or Snore Guard? Yes ☐ No ☐

Are you satisfied with the appearance of your teeth? Yes ☐ No ☐ If no, what would you change? _____

Would you like your teeth to be whiter? Yes ☐ No ☐

I affirm that the information I have provided on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the staff of Smile Oswego Dental to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____ _____

Patient Name (Please Print) Patient Signature Today's Date

Smile Oswego Dental
Family Dental Care

Financial Policy

★ **PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED OUT OF POCKET AMOUNT.** ★

If you have dental insurance, we will help prepare & submit your dental insurance claims as a courtesy to you. By signing this form, you acknowledge any estimate given, is an estimate only and you are financially responsible for all charges regardless of your insurance coverage. Your signature on this form authorizes Smile Oswego Dental to release pertinent information to your insurance company including records of treatment rendered, diagnosis, x-rays, and chart notes and you authorize insurance payments to come directly to Smile Oswego Dental.

If it becomes necessary to effect collections of any amount owed on your account, you will be responsible for all costs and expenses including rebilling and interest charges, missed appointment fees, all collections costs, and reasonable attorney fees. Any account sent to collections will be assessed an additional $100.00 processing fee. Your signature on this form acknowledges and agrees to these terms.

Payment plans and special arrangements must be made ***prior*** to treatment and approved by the office manager.

Returned checks will be charged a flat rate of $25.00 per check, per incident.

Balances older than 60 days from the date of service, regardless of insurance, may be subject to the following interest charges. Interest is calculated at a rate of 1.5% per month (or 18% annually or a $5.00 rebilling fee-whichever is greater) and applied monthly to any unpaid account balances.

For your convenience, we accept most major credit cards. We also offer additional payment plans through Care Credit, an outside financing group.

Broken Appointment Policy

When you make an appointment with us, we reserve time exclusively for you because you are important to us. Should you need to make any changes to your scheduled appointment, we kindly ask that you give us 48 business hours' notice. Broken appointments without 48 business hours' notice, may be assessed a fee of $25.00 per half hour of scheduled time.

If you would like more information or have any questions, please let us know. We are always happy to help!

_____
Patient Name (Please Print)

_____ _____
Patient Signature (Parent or Guardian if Patient is a Minor) Date

Smile Oswego Dental
Marcus Uchida, DMD • Fadi Ibsies, DMD
17510 Provost St., Suite 205 Lake Oswego, OR 97034 • (503) 765-5555 • www.smileoswegodental.com

Smile Oswego Dental

Family Dental Care

HIPAA Acknowledgement & Consent

The staff at Smile Oswego Dental is committed to maintaining the confidentiality of your personal, financial and health information. We are required by applicable federal and state laws to maintain the privacy of your personal health information. We are also required to give you this notice. This notice took effect in April 2003 and will remain in effect until we replace it.

By signing this form, you consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge that you are aware of our needs to share information and received your rights notification explaining in detail our office policy and information sharing policy.

You have the right to revoke this consent at any time by giving us written notification. We will honor the request from the day we received your written notification. Please understand that it will not affect any action taken before we received the revocation, and we may decline to treat you or continue treating you if you revoke this consent.

We reserve the right to change our privacy policies described in our office patient right privacy policy and information practices. If we do change our practices, we will make available a revised patient and information privacy update statement.

We request that you provide notification to us of any changes in your personal information we maintain for you in a timely manner.

You may obtain a copy of Notice of Privacy Practices by contacting Dr. Ibsies at (503) 607-2222 or mailing us your request in writing to: Smile Linn Dental Attn: Dr. Ibsies 18750 Willamette Dr. Suite B2 West Linn, OR 97062

By singing this form, you confirm you have read the above information and have received a copy of this office's Notice of Privacy Practices. Your signature also gives consent to Dr. Marcus Uchida, DMD & staff to use and disclose your protected health information to carry out treatment, payment activities and health care operations.

_____

Patient Name (Please Print)

_____ _____

Patient Signature (Parent or Guardian if Patient is a Minor) Date

_____

For Office Use Only

We attempted to obtain a written acknowledgement of Receipt of Notice of Privacy Policy and Information Practices, but it could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier kept us from obtaining acknowledgement
_____ An emergency situation kept us from obtaining acknowledgement
_____ Other_____