Dental EXCELLENCE

670 Superior Court #101
Medford, OR 97504-6179
P: (541)779-6170
F: (541)779-0989

NAME: _____ PREFERRED NAME: _____ DATE: _____

DOB: _____ SSN: _____ MALE / FEMALE EMAIL: _____

PHONE: _____ *CELL – HOME – OTHER* PHONE: _____ *CELL – HOME – OTHER*

MAILING ADDRESS: _____

SPOUSE NAME: _____ DOB: _____ PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

PREVIOUS DENTAL OFFICE: _____ PHONE: _____

LAST DENTAL VISIT: _____ HOW DID YOU HEAR ABOUT US?: _____

PRIMARY DENTAL INSURANCE NAME: _____ PHONE: _____

ID# _____ GROUP#: _____

SUBSCRIBER NAME: _____ DOB: _____ SSN: _____

SUBSCRIBER EMPLOYER: _____

SECONDARY DENTAL INSURANCE NAME: _____ PHONE: _____

ID# _____ GROUP#: _____

SUBSCRIBER NAME: _____ DOB: _____ SSN: _____

SUBSCRIBER EMPLOYER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE 1: _____ PHONE 2: _____

FINANCIALLY RESPONSIBLE INDIVIDUAL *(if other than self)*: _____

RELATIONSHIP: _____ PHONE 1:_____ PHONE 2:_____

BILLING ADDRESS: _____

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ **DATE:** _____

SIGNATURE: _____ **DATE:** _____

ANNUAL PATIENT INFORMATION UPDATE: PLEASE MARK ANY CHANGES ABOVE AND THEN SIGN BELOW

SIGNATURE: _____ CHANGES MADE: Y / N DATE: _____

SIGNATURE: _____ CHANGES MADE: Y / N DATE: _____

SIGNATURE: _____ CHANGES MADE: Y / N DATE: _____

MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

CURRENT PHYSICIAN NAME: _____ PHONE: _____

CURRENT PHYSICAL HEALTH: GOOD / FAIR / POOR DO YOU SMOKE OR USE CHEWING TOBACCO? YES / NO

ARE YOU CURRENTLY UNDER CARE OF A PHYSICIAN? YES / NO

IF YES, PLEASE EXPLAIN: _____

_____

ARE YOU TAKING ANY PRESCRIPTIONS / OVER THE COUNTER DRUGS? YES / NO

IF YES, PLEASE LIST EACH ONE: _____

_____

WOMEN: ARE YOU CURRENTLY TAKING BIRTH CONTOL? YES / NO

ARE YOU CURRENTLY PREGNANT OR TRYING TO GET PREGNANT? YES / NO

ARE YOU CURRENTLY NURSING? YES / NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?
(EVEN IF NO, YOU MUST CIRCLE THE OPTION THAT APPLIES)

Y N	ANEMIA	Y N	HEMOPHILIA/ABNORMAL BLEEDING
Y N	ARTIFICAL BONES/JOINTS/VALVES	Y N	HEPATITIS
Y N	ARTHRITIS	Y N	HIGH BLOOD PRESSURE
Y N	BLOOD TRANSFUSION	Y N	HIV+/AIDS
Y N	CANCER/CHEMOTHERAPY	Y N	KIDNEY PROBLEMS
Y N	CONGENITAL HEART DEFECT	Y N	MITRAL VALVE PROLAPSE
Y N	DIABETES	Y N	PSYCHIATRIC PROBLEMS
Y N	DIFFICULTY BREATHING	Y N	RADIATION
Y N	DRUG/ALCOHOL ABUSE	Y N	RHEUMATIC/SCARLET FEVER
Y N	EMPHYSEMA/GLAUCOMA	Y N	SEVERE/FREQUENT HEADACHES
Y N	EPILEPSY/SEIZURES/FAINTING SPELLS	Y N	SHINGLES
Y N	FEVER BLISTERS/HERPES	Y N	SICKLE CELL DISEASE/TRAITS
Y N	HEART ATTACK/STROKE	Y N	SINUS PROBLEMS
Y N	HEART MURMUR	Y N	TUBERCULOSIS (TB)
Y N	HEART SURGERY/PACEMAKER	Y N	ULCERS/COLITIS

ALLERGIES: *(EVEN IF NO, YOU MUST CIRCLE THE OPTION THAT APPLIES)*

Y N	ASPIRIN
Y N	ERYTHROMYCIN
Y N	PENICILLIN
Y N	CODEINE
Y N	JEWELRY/METALS
Y N	TETRACYCLINE
Y N	LATEX
Y N	DENTAL ANESTHETICS

OTHER: _____

OTHER: _____

LIST ANY SERIOUS MEDICAL CONDITIONS: _____

HAVE YOU EVER TAKEN PHEN-FEN? YES / NO HAVE YOU EVER TAKEN BISPHOSPHONATES YES / NO

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL TREATMENT? YES / NO

SIGNATURE: _____ **DATE:** _____

ANNUAL HEALTH HISTORY UPDATE: PLEASE MARK ANY CHANGES ABOVE AND THEN SIGN BELOW

SIGNATURE: _____ CHANGES MADE: Y / N DATE: _____

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Dental EXCELLENCE

NOTICE OF PRIVACY PRACTICES

I UNDERSTAND THAT, U NDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS, SUCH AS INSURANCE COMPANIES.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS

I HAVE READ AND UNDERSTAND THIS OFFICE'S NOTICE OF PRIVACY PRACTICES OR I HAVE BEEN OFFERED A PERSONAL COPY OF THIS NOTICE TO READ AND FOR MY RECORDS. I UNDERSTAND THAT THIS OFFICE HAS THE RIGHT TO CHANGE IT'S NOTICE OF PRIVACY PRACTICES AND THAT I MAY CONTACT THIS OFFICE AT ANY TIME TO OBTAIN A CURRENT COPY OF THEIR NOTICE OF PRIVACY PRACTICES.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

PLEASE SPECIFY IF THERE ARE ANY INDIVIDUALS THAT YOU GIVE PERMISSION FOR US TO SHARE YOUR PRIVATE HEALTH INFORMATION WITH (PHI). INCLUDING BUT NOT LIMITED TO: DENTAL APPOINTMENTS, TREATMENT PLANS AND TREATMENT COSTS, FINANCIAL INFORMATION ETC.

KEEP IN MIND THIS INCLUDES:
CONFIRMING, CANCELLING OR RESCHEDULING ANY APPOINTMENTS ON YOUR BEHALF!
*WE CANNOT RELEASE **ANY** OF YOUR PRIVATE HEALTH INFORMATION TO ANY INDIVIDUAL WHO IS NOT LISTED BELOW*

NAME: _____PHONE #_____ RELATIONSHIP: _____

NAME: _____PHONE #_____ RELATIONSHIP: _____

☐ **I DECLINE DISCLOSING ANY OF MY PRIVATE HEALTH INFORMATION WITH ANYONE ELSE EXCEPT HEALTHCARE PROVIDERS OR/AND INSURANCE COMPANIES AS PERMITTED BY HIPAA.**

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVATE PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED, BECAUSE:

- INDIVUDUAL REFUSED TO SIGN
- COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

ANNUAL HIPAA AND PHI RELEASE UPDATE: PLEASE MARK ANY CHANGES ABOVE AND THEN SIGN BELOW

SIGNATURE: _____ CHANGES MADE: Y / N DATE: _____

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FINANCIAL RESPONSIBILITY

THE FOLLOWING ARE THE FINACIAL TERMS OF THIS OFFICE. YOUR SIGNATURE BELOW SIGNIFIES YOUR ACCEPTANCE OF THESE TERMS AS A CONDITION OF THE SERVICES RENDERED AND YOUR RECEIPT OF A COPY OF THIS AGREEMENT.

1. **PAYMENT:** PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED.. WE ACCEPT PAYMENT BY CASH, CHECK, DEBIT OR CREDIT CARD AS WELL AS CARE CREDIT AND LENDING CLUB. **A FEE OF $50 WILL BE CHARGED FOR ANY NSF CHECKS AND IS THE PATIENT RESPONSIBILITY TO PAY.**
2. **INSURANCE:** INSURANCE INFORMATION MUST BE PROVIDED PRIOR TO RECEIVING SERVICES AND IT IS THE RESPONSBILTY OF THE PATIENT, NOT THE PROVIDER, TO KNOW WHAT IS COVERED OR EXCLUDED FROM HIS/HER PLAN. AS A COURTESY TO OUR PATIENTS, WE DO OUR BEST TO ACQUIRE YOUR DENTAL BENEFITS TO PROVIDE YOU WITH THE MOST ACCURATE ESTIMATES FOR TREATMENT AS WE CAN. HOWEVER, IT IS ULTIMATELY THE RESPONSBILITY OF THE PATIENT TO UNDERSTAND THEIR DENTAL BENEFITS AND YOU ARE RESPONSIBLE FOR ANY BALANCE REMAINING ONCE CLAIMS HAVE PROCESSED.
3. **PAST DUE:** ANY ACCOUNTS WITH CHARGES THAT REMAIN UNPAID FOR 90 DAYS FROM THE LAST DATE OF SERVICE WILL BE TREATED AS DELINQUENT OR “PAST DUE”. PAST DUE ACCOUNTS ARE SUBJECT TO FINANCE CHARGES AND/OR ACCOUNT CLOSURE AND MAY SUBSEQUENTLY BE REVIEWED FOR ASSIGNMENT TO COLLECTIONS. IN THE EVENT THAT LEGAL ACTION IS TAKEN TO COLLECT ANY AMOUNTS OWED, THE PREVAILING PARTY SHALL BE ENTITLED TO RECOVER THEIR REASONABLE ATTORNEY FEES.
4. **FINANCE CHARGES:** FINANCE CHARGES ARE IMPOSED ON THE ACCOUNT IF NOT PAID IN FULL WITHIN 30 DAYS OF THE DATE OF THE FIRST STATEMENT SENT TO YOU BY OUR OFFICE FOLLOWING ANY INSURANCE PAYMENTS. CHARGES ARE INCURRED AT A **PERIODIC RATE OF 1.5% PER MONTH (ANNUAL PERCENTAGE RATE OF 18%)**. THERE IS A MINIMUM FINANCE CHARAGE OF $1.00 PER MONTH.
5. **CANCELLATIONS: A 48 BUSINESS HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS OR FOR RESCHEDULING ANY APPOINTMENTS.** ANY APPOINTMENTS THAT DO NOT MEET THESE REQUIREMENTS ARE SUBJECT TO A CANCELLATION FEE. ALL NO SHOW APPOINTMENTS ARE ALSO SUBJECT TO A FEE. THIS FEE MAY BE WAIVED AT THE DISCRETION OF THE OFFICE. **HYGIENE APPOINTMENT FEE: $50 PER APPOINTMENT. DOCTOR APPOINTMENT FEE: ANY APPOINTMENTS UNDER 2 HOURS WILL BE CHARGED AT $100 PER HOUR. ANY APPOINTMENTS OVER 2 HOURS WILL BE CHARGED AT $250 PER HOUR.**
6. **ACCOUNT CLOSURE:** WE RESERVE THE RIGHT TO DECLINE FURTHER SERVICES ON PATIENTS IF THE ACCOUNT IS DELINQUENT OR PAST DUE. THE ACCOUNT CAN BE OPEN AGAIN ONCE THE ACCOUNT IS PAID IN FULL. WE RESERVE THE RIGHT TO REQUIRE ANY PATIENTS WHO HAVE HAD A DELINQUENT ACCOUNT TO PAY IN FULL FOR ALL SERVICES PRIOR TO RENDERING TREATMENT.
7. **FAMILY EXPENSES:** OREGON LAW PROVIDES THAT A SPOUSE MAY BE FINANCIALLY RESPONSIBLE FOR FAMILY EXPENSES INCURRED BY THE OTHER SPOUSE OR FOR THE BENEFIT OF A MINOR CHILD. IT IS AGREED THAT ALL CHARGES OR FEES INCURRED OR IMPOSED PURSUANT TO THIS AGREEMENT ARE FAMILY EXPENSES FOR WHICH BOTH SPOUSES ARE FINANCIALLY RESPONSIBLE. IN THE EVENT THAT ONLY ONE SPOUSE SIGNS THIS AGREEMENT, THE SIGNING SPOUSE AGREES TO PROVIDE A COPY OF THIS AGREEMENT TO THEIR SPOUSE. IT IS AGREED THAT ANY NON-SIGNING SPOUSE IS FINANCIALLY RESPONSIBLE FOR ALL AMOUNTS OWED UNDER THIS AGREEMENT UNLESS OTHER ARRANGEMENTS ARE AGREED TO IN WRITING.
8. **COMMUNICATION CONSENT:** YOU AGREE, IN ORDER FOR US TO SERVICE YOUR ACCOUNT OR TO COLLECT AMOUNTS YOU MAY OWE, WE MAY CONTACT YOU BY TELEPHONE AT ANY TELEPHONE NUMBER YOU PROVIDE. WE MAY ALSO CONTACT YOU BY SENDING TEXTS, EMAILS AND MAIL. METHODS OF CONTACT MAY INCLUDE PRERECORDED, ARTIFICAL VOICE MESSAGES AND OR THE USE OF AN AUTOMATIC DIALING DEVICE, AS APPLICABLE. YOUR CONSENT TO THESE COMMUNCATIONS APPLIES THOSE INITIATED BY OUR OFFICE, OR BY AN AGENT, ATTORNY OR COLLECTIONS AGENCY ACTING ON OUR BEHALF.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO THE TERMS:

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

ANNUAL PATIENT INFORMATION UPDATE: PLEASE MARK ANY CHANGES ABOVE AND THEN SIGN BELOW

SIGNATURE: _____ CHANGES MADE: Y / N DATE: _____

SIGNATURE: _____ CHANGES MADE: Y / N DATE: _____

SIGNATURE: _____ CHANGES MADE: Y / N DATE: _____