Evergreen DENTAL

Welcome To Our Office!

To help us meet all your dental needs, please fill out this form completely.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Name: _____ MI_____ Preferred Name: _____ Date_____
First Last

Sex: ❑ Male ❑ Female Preferred Pronoun: ❑ She/her ❑ He/him ❑ They/them ❑ Other _____

SSN # _____Birthdate _____Home Phone _____ Cell _____

Address _____City_____ State_____ Zip_____

E-Mail _____ Driver's License #_____ State_____

When confirming appointments, how do you prefer to be contacted? ❑ Phone ❑ Email ❑ Text message

Marital Status: ❑ Married ❑Single ❑ Divorced ❑ Separated ❑ Widowed

Patient's or Parent's Employer _____ Work phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Patent's Name_____ Employer _____ Work Phone _____

Person to Contact in Case of an Emergency _____ Phone _____

How did you hear about our office? (Check All That Apply)

❑ Google ❑ Face Book ❑ Website ❑ Drive By
❑ Friend _____ ❑ Patient_____

Responsible Party (If Other Than Yourself)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Contact # _____ Birthdate _____

Employer _____ Work Phone _____ SSN # _____

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No ❑ Unknown

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Insurance Company _____

Ins Co. Address _____ City _____ State _____ Zip _____

Group # _____ Policy/ID # _____

Patient Medical History

Name _____MI _____ Preferred Name _____

	Yes	No
1. Are you under a physician's care now?	❑	❑
2. Have you ever been hospitalized for any surgical operations or serious illness? If yes, please explain _____ _____	❑	❑
3. Are you taking medications including non-prescription medicine? If yes, please list _____ _____	❑	❑
4. Are you currently taking or have you ever taken osteoporosis medications in the past? If so, how long? _____ Which ones? _____	❑	❑
5. Do you use Tobacco products?	❑	❑
6. Do you use controlled substances? Or recreational drugs?	❑	❑

7. Are You Allergic to:

	Yes	No
Local Anesthetics (e.g. lidocaine)	❑	❑
Penicillin /	❑	❑
Sulfa Drugs	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Ibuprofen	❑	❑
Tylenol	❑	❑
Codeine	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex rubber	❑	❑
Other _____	❑	❑

8. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you Nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Hearing Impaired	❑	❑	Sexually transmitted Disease	❑	❑
Heart Attack / Failure	❑	❑	Heart Disease	❑	❑	Stomach Troubles / Ulcers	❑	❑
Rheumatic Fever	❑	❑	Mitral Valve Prolapse	❑	❑	Cold Sores / Fever Blisters	❑	❑
Swelling of Limbs	❑	❑	Cardiac Pacemaker	❑	❑	Frequent Cough	❑	❑
Fainting Spells / Vertigo	❑	❑	Heart Murmur	❑	❑	Neck / Back Pains	❑	❑
Excessive Bleeding	❑	❑	Irregular Heartbeat	❑	❑	Chest Pains	❑	❑
Anaphylaxis	❑	❑	Angina	❑	❑	Easily Winded	❑	❑
Low Blood Pressure	❑	❑	Frequently Tired	❑	❑	Stroke	❑	❑
Epilepsy / Seizures	❑	❑	Anemia	❑	❑	Hay Fever / Allergies	❑	❑
Cancer	❑	❑	Emphysema / COPD	❑	❑	Hives or Rash	❑	❑
Radiation Therapy	❑	❑	Tuberculosis	❑	❑	Glaucoma	❑	❑
Diabetes	❑	❑	Asthma	❑	❑	Recent Weight Loss	❑	❑
Kidney Diseases	❑	❑	Arthritis / Gout	❑	❑	Liver Disease	❑	❑
AIDS or HIV Infection	❑	❑	Joint Replacement or Implant	❑	❑	High Cholesterol	❑	❑
Thyroid Problem	❑	❑	Hepatitis / Jaundice	❑	❑	Other _____	❑	❑

Patient Dental History

Name of Previous Dentist/Location _____ Date of Last Exam/Cleaning _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain in any of your teeth	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries	❑	❑
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑

	Yes	No
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions?	❑	❑
13. Have you ever had any orthodontic treatments?	❑	❑
14. Do you ever wear dentures or partials? If yes, date of placement _____	❑	❑
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑
16. Do you like your smile?	❑	❑

Signature of Patient/Guardian:_____

Evergreen DENTAL

Financial Policy

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following financial policy for our patients. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Therefore, we would like to take the time now to fully explain our policy to you in order to avoid any misunderstanding in the future.

We accept cash, checks, debit cards, CareCredit, American Express, Visa, Discover, and Mastercard. Your treatment needs to be paid for at the time of service. If you need to make payments, you can apply for CareCredit in this office.

We accept dental insurance and, as a service to our patients, will be happy to bill the insurance carrier for you. We have found that insurance rarely pays 100% of the fee for service, therefore we ask that all estimated co-payments, based on the percentage your insurance should pay, be paid for ***at the time of service.*** After the insurance had paid, you will be sent a final statement showing any remaining balance due to this office. That final payment is due upon receipt of statement. Please remember that whatever your insurance arrangements are, you are responsible for the payment of your dental care.

Balances exceeding 60 days will be charged a service fee of 18% per annum. Returned checks will be charged a fee of $25.00.

An appointment is a reservation of our office and staff for your treatment needs. This time is deprived from someone else if we do not have adequate notice for cancellations. Please give us a minimum of 24 hours' notice from our last business day if you cannot keep your appointment. ***A fee of $100.00 will be charged if you miss your appointment without adequate notice.***

In some instances, insurance payments may be more than our office estimated for coverage. In this case any credit of $15.00 or less will remain on your account for future treatment unless you request otherwise. Any credits for $15.01 or greater our office will call to notify you of and issue a refund check or leave on account at your request.

I have read this financial policy and understand that, regardless of any insurance coverage I may have, I am fully responsible for payment of my account within the limits of this credit policy. I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees, including billing costs, collection costs, attorney's fees, and any court costs.

Date: _____ Patient Name: _____
Please print

Patient or Responsible Party Signature: _____
Please sign

Evergreen DENTAL

HIPAA CONSENT

The privacy Rule (part of the Health Insurance Portability and Accountability Act of 1996) became effective April 14th 2001. The Privacy Rule establishes a federal requirement that most doctors, hospitals and other health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations. Some examples requiring consent include: phoning in prescriptions, referral appointments, insurance billing, etc. This consent gives health care providers, which have a direct treatment relationship with a patient, permission to use and disclose minimum necessary health information.

I give Evergreen Dental my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Evergreen Dental's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Evergreen Dental has the right to change their privacy practices and that I may obtain any revised notices at Evergreen Dental.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Evergreen Dental is not required to agree to the request. If Evergreen Dental agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Name: _____ Date of Birth: _____
Please print

Patient Signature: _____ Date: _____

If reviewing Consent on behalf of Patient, please sign below

Personal Representative Name: _____Relationship: _____
Please print

Person Representative Signature: _____ Date: _____

Evergreen DENTAL

Health Information Consent Form

Evergreen Dental uses health information within their office to provide the best dental care possible. Evergreen Dental has my consent to use or disclose my protected health information* to carry out treatment, obtain payment from insurance companies, and for health care operations like quality reviews. In addition, they may share health information with physicians, referring dentists, clinical laboratories, pharmacies or other health care personnel providing treatment. Health information may be included with an invoice used to collect payment for treatment received. The same applies to insurance forms filed via mail or sent electronically.

Because Evergreen Dental believes regular care is very important to oral and general health, reminders will be given of scheduled appointments or appointments to be scheduled. These communications are an important part of Evergreen Dental's philosophy of partnering with patients to be sure they receive the best dental care. This may include postcards, letters, telephone reminders, texts, or electronic reminders such as e-mail (unless otherwise indicated).

I have been informed that I may review Evergreen Dental's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Evergreen Dental has the right to change their privacy practices and that I may obtain any revised notices at Evergreen Dental.

I understand I have the right to request a restriction of how my protected health information is used. However, I also understand that Evergreen Dental is not required to agree with this request. If Evergreen Dental agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Name: _____ Relationship to Patient: _____
Please print (if other than self)

Signature: _____ Date: _____

*Protected health information to include radiographs, intra-oral and extra-oral pictures, and chart notations.

Evergreen DENTAL

Dental Record & Radiograph Release Form

Oftentimes it is necessary to obtain your complete dental history in order to devise a treatment plan that will properly address all your immediate and long-term dental needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Patient Name: _____ DOB: _____
Please print

Previous Dental Office _____

Address _____

City _____ State _____ Zip _____

I authorize Evergreen Dental to request and receive any and all previous dental or medical charting as they pertain to the above-named patient's dental and treatment. Please remit any current radiographs or pertinent dental information to:

Evergreen Dental
J. Scott Travelstead D.M.D.
1823 NW Kings Blvd.
Corvallis, OR 97330
(541)754-6400
FAX: (541)754-2081
info@evergreendentalcorvallis.com

_____ DOB _____/_____/_____
Print Name of Patient or Legal Guardian

_____ Date _____/_____/_____
Signature of Patient or Legal Guardian

All patients over the age of 18 MUST sign their own forms. Patients under the age of 18 CAN NOT sign for themselves. Only a parent or legal guardian may sign for a patient under the age of 18.