

**PATIENT INFORMATION**

Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

PatientName \_\_\_\_\_  
                                  Last                                   First                                   Middle

Address \_\_\_\_\_  
                  Number and Street                                   City                                   State                                   Zip

Date of Birth \_\_\_ / \_\_\_ / \_\_\_    Male/Female    Social Security # \_\_\_\_\_

Person responsible for account \_\_\_\_\_

Single/Married    Spouse's Name \_\_\_\_\_    Referred by \_\_\_\_\_

Employer \_\_\_\_\_    Occupation \_\_\_\_\_    Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_    Relationship \_\_\_\_\_    Phone \_\_\_\_\_

**DENTAL COVERAGE**

---

Name of Insurance Co.                                   Address                                   Group Number

---

Insured Employer                                   Bus Phone                                   /    /

---

Name of Insured Person                                   Insured ID#                                   Insured Date of Birth

If patient is not the insured, please indicate relationship \_\_\_\_\_

**DUAL COVERAGE**

---

Name of Insurance Co.                                   Address                                   Group Number

---

Insured Employer                                   Work Phone

---

Names of Insured Person                                   Insured ID #                                   Insured Date of Birth

## PERSONAL HEALTH INFORMATION

PATIENT \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

Please answer all the questions for our Dental/Medical History Records

\_\_\_ Are you in pain or discomfort with your teeth, gums or bite at the present time? If yes, what areas \_\_\_\_\_

When was your last visit to a dentist? \_\_\_\_\_

When did you last have X-Rays? \_\_\_\_\_

May we take X-Rays we feel are necessary? \_\_\_\_\_

Has a dentist or hygienist ever shown you how to properly clean your teeth?

\_\_\_\_\_

What are you doing to clean your mouth at the present time?

\_\_\_\_\_

Do you or have you ever had:

\_\_\_ Problems with your bite

\_\_\_ Problems chewing food

\_\_\_ Problems with your jaw or the muscles around your jaw

\_\_\_ Do you grind or clench your teeth?

\_\_\_ Do you have frequent headaches?

\_\_\_ Do you hear popping, clicking or snapping noises when you chew?

\_\_\_ Any loose or slightly mobile teeth

\_\_\_ Problems with your gums (bleeding when you brush or floss)

\_\_\_ Recurring bad taste or odor in your mouth

\_\_\_ Do you have sores, swelling, or blisters on your gums, cheeks, or lips?

If yes, have they been present longer than 3-4 weeks? \_\_\_\_\_

\_\_\_ Do you have teeth that are sensitive to hot and cold?

Is there anything about dentistry that you especially fear or dislike? How can we make your visit more comfortable? \_\_\_\_\_

## MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Date of birth \_\_\_\_\_

\_\_\_\_\_ Have you had any bleeding problems following dental treatment or injuries?

\_\_\_\_\_ Is there any history of Diabetes in your family?

\_\_\_\_\_ Have you recently lost weight unintentionally (with good appetite)?

Do you have or ever had any of the following:

\_\_\_\_\_ Heart Murmur or Heart problems

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Jaundice, hepatitis, liver problems

\_\_\_\_\_ Stroke

\_\_\_\_\_ High or Low blood pressure

\_\_\_\_\_ Cancer

\_\_\_\_\_ Any STD

\_\_\_\_\_ Asthma

\_\_\_\_\_ Thyroid disorder

\_\_\_\_\_ Epilepsy

\_\_\_\_\_ Excessive bleeding or Blood disorder

\_\_\_\_\_ Rheumatic Fever

\_\_\_\_\_ HIV Antibody

\_\_\_\_\_ Aids or Aids related

\_\_\_\_\_ Allergies \_\_\_\_\_

complex (ARC)

\_\_\_\_\_ Joint replacements Date \_\_\_\_\_

\_\_\_\_\_ Current or past Smoker

Are you being treated for any medical conditions or complications at the present time? \_\_\_\_\_

When were you last seen by your doctor? \_\_\_\_\_

Have you had any serious illness or operations \_\_\_\_\_

(Females) Pregnant? \_\_\_\_\_

Please list all medications you are taking including vitamins, oral contraceptives \_\_\_\_\_

Primary care physician, address and phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Have you become sick from or shown any allergy to, or been told not to take:

\_\_\_\_\_ Antibiotics (Penicillin, etc.)

\_\_\_\_\_ Codeine

\_\_\_\_\_ Novocain or other dental anesthetics

\_\_\_\_\_ Other drugs or medicines  
What kind \_\_\_\_\_

**PLEASE READ AND SIGN:**

I give consent to Marc F. Bianco, D.M.D. or hygienist in charge of the care of the patient, whose name is specified at the beginning of this form, to administer any treatment or anesthetics, and to perform such dental services as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

**SIGNATURE OF PATIENT (OR PARENT)** \_\_\_\_\_

Review Date	Comments	Review Date	Comments

## **FINANCIAL POLICY FOR THE OFFICE**

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and excellent dental care.

All accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with our Office Manager.

For accounts which have established arrangements the payment is due upon receipt of the monthly statement. Any balance outstanding more than 60 days will bear interest at 12% per annum.

Insurance is gladly billed as a courtesy to our patients, when you provide us with current information pertaining to your coverage. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance reimbursement is a contract carrier. You are responsible for the payment of your account.

There will be a \$45.00 charge for any broken appointment or appointment not cancelled or rescheduled with a 24 hour notice. If you miss three appointments in a row, it will be determined by Dr. Bianco whether or not we can continue seeing you as a patient. Our time must be used as efficiently as possible to keep our expenses at a minimum and our fees within reasonable limits.

**I HAVE READ THIS CREDIT POLICY AND UNDERSTAND THAT REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. I UNDERSTAND THAT DELINQUENT ACCOUNTS MAY BE ASSIGNED TO A CREDIT REPORTING COLLECTION SERVICE. IF IT BECOMES NECESSARY TO EFFECT COLLECTIONS OF ANY AMOUNT OWED ON THIS OR SUBSEQUENT VISITS, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT CONSENT FORM

Dental Health Associates, P.C.  
Marc F. Bianco D.M.D.  
1133 S.E. 122<sup>nd</sup> Avenue  
Portland, Oregon 97233

I understand that, under 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.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_