PATIENT INFORMATION

Date______________________

Home Phone_________________ Cell _______________Email____________________

Patient Name____
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 _______
Phone:_____________

_____ 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 _____Arthritis
_____ 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 complex (ARC)
_____ Allergies __________
______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) ___________________________________

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 $60.00 charge for any broken appointment or appointment not cancelled or rescheduled with a 24 hour notice. All Saturday Appointments, there will be a fee for all cancellations day of appointment or less than 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. 122nd 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 aide 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: ___________________________