PATIENT INFORMATION

Date_____

Patient Name_____
Last First Middle

Home Phone _____ Cell _____ Email_____

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

DUAL COVERAGE

Name of Insurance Co. Address Group Number

Insured Employer Bus Phone
/ /

Name 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? YES/NO
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

Name_____ Date_____

Cell #: _____ M____ F____ Date of Birth: _____

Email _____

Address: _____

_____ 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 a good appetite)?

Do you have or ever had any of the following **(Please leave blank if no):**

_____ Heart Attack or Heart problems
_____ Jaundice, hepatitis, liver problems
_____ High/Low blood pressure
_____ Any STD
_____ Thyroid disorder
_____ Excessive bleeding or Blood disorder
_____ HIV Antibody
_____ Allergies _____
_____ Joint/Valve replacements _____
_____ High Cholesterol

_____ Diabetes
_____ Stroke
_____ Cancer _____
_____ Asthma
_____ Epilepsy
_____ Rheumatic Fever
_____ Aids or Aids-related complex (ARC)
_____ Current or past Smoker
_____ **Blood thinners/Anticoagulants**

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

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) Are you Pregnant? _____
Please list all medications you are taking including vitamins, oral contraceptives
_____
_____

Primary care physician and phone: _____
Emergency Contact and Number: _____

PLEASE READ, SIGN, AND DATE BELOW

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): _____

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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, 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 (**Leave blank if self**): _____

Date: _____

FINANCIAL POLICY FOR THE OFFICE

In the interest of good healthcare 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.

The payment is due upon receipt of the monthly statement for accounts that have established arrangements**. 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 an $80.00 charge for any broken appointment or appointment not canceled or rescheduled with a 24-hour notice.
For 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 consecutive appointments, Dr. Bianco will determine whether we can continue to see 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.

X_____ _____
Signature **Date**