Patient Registration

Patient Information:

First name:_____ Last name: _____ Middle Initial:_____
Address:_____
City, State, Zip:_____
Home phone:(___) _____ -_____ Work phone: (___)_____-_____ Cell: (____)_____-_____
Email Address:_____
Birth date: _____ Social Security #: _____
Sex at Birth: □ Male □ Female □ _____ Gender: □ Male □ Female □ _____
Pronouns: □ He/His □ She/Hers □ They/Them
Do you use a pre-medication prior to dental treatment? _____

Emergency contact: _____ (____)_____-_____

Responsible Party:

□: Same as above

First name:_____ Last name: _____ Middle Initial:_____
Address:_____
City, State, Zip:_____
Home phone:(___) _____ -_____ Work phone: (___)_____-_____ Cell: (____)_____-_____
Birth date: _____ Social Security #: _____
□Responsible Party is also the Policy Holder for Patient
□Primary Insurance Holder
□Secondary Insurance Holder

Insurance Information (please provide insurance card)

Name of Insured:_____
Relationship to patient: □ Self □Spouse □ Parent □ Other
Insured SSN:_____ Insured Date of Birth: _____
Employer:_____ Insurance Company:_____
Insurance phone number: _____ Group number:_____
Subscriber ID #:_____

Secondary Insurance Information

Name of Insured:_____
Relationship to patient: □ Self □Spouse □ Parent □ Other
Insured SSN:_____ Insured Date of Birth: _____
Employer:_____ Insurance Company:_____
Insurance phone number: _____ Group number:_____
Subscriber ID #:_____

Patient or Guardian Signature: _____

Clark _Eldredge Dental LLC

Medical

Patient Name: Birth Date: Date Created:

Although our primary focus is your dental wellness, medical conditions & medication that you may be taking could have an impact on the dentistry you receive.

Are you allergic to any of the folloiwng? If so, please indicate.

☐ Acrylic	☐ Aspirin	☐ Codeine	☐ Latex
☐ Local Anesthetics	☐ Metal	☐ Penicillin	☐ Sulfa Drugs

Other? If yes, please list. ◯ Yes ◯ No If yes

Are you taking any medications? If yes, please list.	◯ Yes ◯ No	If yes
Do you take / have you taken Phen-Fen or Redux? If yes, how long?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel, or other bisphophonates? If yes, how long?	◯ Yes ◯ No	If yes
Are you under a physician's care? If yes, please provide their name.	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation? If yes, please explain.	◯ Yes ◯ No	If yes
Have you ever had a serious head / neck injury? If yes, please explain.	◯ Yes ◯ No	If yes
Are you on a special diet? If yes, what kind?	◯ Yes ◯ No	If yes
Do you use controlled substances? If yes, please list.	◯ Yes ◯ No	If yes
Do you use tobacco? If yes, how frequently?	◯ Yes ◯ No	If yes
Have you ever been told to take antibiotics prior to dental appointments? If yes, please explain.	◯ Yes ◯ No	If yes

Please indicate any of the following that apply to you.

☐ Pregnant (or possibly) ☐ Nursing ☐ Taking Oral Contraceptives

Do you have, or have you had, any of the following?

AIDS/ HIV Positive	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Arthritis / Gout	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Cold Sores/ Fever Blisters	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Fainting / Dizziness	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Heart Attack / Failure	◯ Yes ◯ No
Heart Disease	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No
Hepatitis A	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Herpes	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	HPV	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Infective Endocarditis	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Shingles	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Stomach / Intestinal Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Thyroid / Parathyroid	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Ulcers	◯ Yes ◯ No	Unexpected Weight Change	◯ Yes ◯ No		

Have you ever had a serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the information provided on this form is accurate. I understand that providing incorrect information can be dangerious to my (or the patient's) health and it is my responsiblity to inform the dental office of any medical changes.

Signature of Patient, Parent or Guardian:

X Date:_____

Dental History

Name _____
Previous dentist? _____
How long were you a patient there? _____
Approximate date of most recent dental exam? _____

Personal History

Do you have any immediate dental concerns? _____ Yes / No
Are you fearful of dental treatment? How fearful, on a scale of 1-10? _____ Yes / No
Have you ever had complications from past dental treatment? _____ Yes / No
Have you ever had difficulty getting numb or had any reactions to local anesthetic? _____ Yes / No
Have you had any teeth removed or missing teeth that never developed? _____ Yes / No
How important is your dental health to you on a scale from 1-10? _____
How would you rate your current dental health on a scale from 1-10? _____

Gum and Bone

Do your gums bleed or are they painful with brushing or flossing? _____ Yes / No
Have you ever been treated for gum disease? _____ Yes / No

Tooth Structure

Have you had any cavities within the past 3 years that you know of? _____ Yes / No
Are any teeth sensitive to hot/cold, biting, or sweets? _____ Yes / No
Do you frequently get food caught between any teeth? _____ Yes / No

Oral Cancer Risk Assessment

Any history of tobacco use? _____ Yes / No
Any history of marijuana use? _____ Yes / No
Any history of alcohol abuse? _____ Yes / No
Have you ever been diagnosed with HPV? _____ Yes / No

Jaw Joint & Sleep

Do you have problems (pain, sound, limited opening, locking) with your jaw joint? _____ Yes / No
Has anyone ever told you that you clench or grind your teeth at night? _____ Yes / No
Do you wake up with headaches, soreness in the cheeks or an awareness of your teeth? _ Yes / No
Do you wear a bite appliance at night? _____ Yes / No
Do you snore at night? _____ Yes / No
Do you usually feel well-rested when you wake up? _____ Yes / No
Do you have any daytime sleepiness (falling asleep when you don't want to)? _____ Yes / No
Have you ever been diagnosed with obstructive sleep apnea? _____ Yes / No

Smile Characteristics

If you could change anything about your smile what would you change? _____
_____
Would you be interested in hearing about teeth whitening options? _____ Yes / No
Have you noticed your teeth becoming more crooked, crowded or overlapped? Yes / No
Have you ever considered straightening your teeth? _____ Yes / No

Clark & Eldredge Dental

2550 NW Century Drive
Corvallis, OR 97330
541-754-0600

FINANCIAL POLICY AND AGREEMENT

We pledge ourselves to providing you with the best in oral healthcare. We will do everything possible to serve you in a professional, courteous, and friendly manner. Our fees are based on the quality materials used and the time, effort, and skill required in performing your needed treatment. We would be happy to discuss our charges and how they relate to your particular situation. We will strive to maximize your insurance benefits and/or create a payment plan that best meets your needs. We recognize that temporary financial situations may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. We hope the following information will answer any questions you may have.

General Payment Terms

Fees for diagnosis, consultation, x-rays, or other similar services are due at the time of service if not covered by your dental insurance. A treatment plan will be created with estimated costs shown for any future treatment appointments needed. A payment may be required at the time of service if you have not already entered into a payment plan. Payment plans are not available for bleaching services. We accept cash, check, American Express, Discover, Master Card, and Visa. **If you have questions about the amount due today, please ask the receptionist.**

Insurance Payments

You are fully responsible for knowing your own insurance coverage limitations. Your deductible is due at the time of service and you are liable for any charges incurred as a result of services rendered regardless of how your insurance pays your claim. The treatment plan we provide is our best **estimate** of what your insurance will pay and is not a guarantee of payment.

Failed / Cancelled Appointment Fee

In order to keep the cost of dental care down, we try to maintain an efficient appointment system. When patients fail to keep their appointment or cancel at the last minute our system becomes less effective. We require at least 24 hour notice if your appointment needs to be rescheduled in order to avoid a loss of opportunity for other patients. A **$40.00 Missed Appointment Fee** will be assessed if an appointment is missed without required notification.

I certify that I have read and understand the above information. I authorize and request my insurance company to pay my claim directly to Clark & Eldredge Dental. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. In case of default on payment of my account balance, I agree to pay collection cost and reasonable attorney fees incurred in attempting to collect my outstanding account balance.

Patient Printed Name: _____

Patient or Guardian Signature: _____ Date: _____

CLARK & ELDREDGE DENTAL

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

_____
(Or Signature of Legal Representative) Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____