HEALTH HISTORY

Alder Dental Group

Jori Grady, DMD

Geoffrey Berg, DMD

Name: _____

Birthdate: _____ Age: _____

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____ City: _____

Date of last dental visit: _____ Date of last dental x-rays:_____

Please check if you have or have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Grinding teeth
- ☐ Pain in mouth
- ☐ Sores or growths in mouth
- ☐ Clicking or popping jaw
- ☐ Loose teeth or broken fillings
- ☐ Food collection between teeth
- ☐ Periodontal treatment
- ☐ Sensitivity to sweets
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity when biting

Are you satisfied with the appearance of your teeth? _____

Please rate your smile: 0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Physicians Name: _____ Date of last physical: _____

Have you had any serious illness or operations? yes____ no ____ If yes, describe: _____

For female patients only:
Are you pregnant? yes____ no ____ Nursing? yes____ no ____ Taking birth control pills? yes____ no ____

Do you require antibiotics prior to dental treatment? yes____ no ____

Please check if you have or have had any of the following:

- ☐ AIDS
- ☐ Alzheimers, Dementia, memory loss
- ☐ Anemia
- ☐ Artificial joints
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Kidney disease
- ☐ Latex allergy
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Psychiatric care
- ☐ Respiratory disease
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other (please describe on line below)

Other: _____

MEDICATIONS: _____

_____

ALLERGIES:_____

_____

By signing, I acknowledge that I have read and answered the above questions to the best of my knowledge.

_____ _____

Signature of patient (or of parent or guardian if patient is a minor) Date

7110 SW Hazel Fern Road
Tigard, OR 97224
(503) 431-3200

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PATIENT INFORMATION

GUARANTOR INFORMATION *(Responsible person for account - parent or guardian if patient is a minor)*

Legal name: _____Preferred Name:_____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Mobile: _____ Work: _____

Email: _____ Social Security No: _____

Employer: _____ Who should we thank for referring you to us? _____

If married: Spouse's Name _____ Sp. DOB: _____ Sp. Employer_____

PATIENT INFORMATION *(Complete if patient is a minor. If the patient is the guarantor, you may skip this section)*

Legal name: _____ Preferred Name:_____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Mobile: _____ Work: _____

Relationship to guarantor: _____ Social Security No: _____

INSURANCE INFORMATION

Policy holder name: _____ Birthdate: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Insurance carrier: _____

Subscriber ID No: _____ Group No: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

*If you have **secondary** dental insurance coverage, please complete the section below*

Policy holder name: _____ Birthdate: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance carrier: _____ Subscriber ID No: _____ Group No:_____

Insurance Co. Address: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____ Phone: _____

AUTHORIZATION & RELEASE

By signing, I acknowledge that I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient (or of parent or guardian if patient is a minor) Date

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FINANCIAL AGREEMENT & POLICIES

This statement is to inform you of our financial policy. We are committed to providing you with the finest quality care using only the best material and technology available in the market today. All charges you incur are your responsibility regardless of your insurance coverage.

Insurance coverage is a valuable asset in restoring and maintaining good oral health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. We may also be able to determine benefits prior to treatment, which provides you with important deductible and co-payment information. Our relationship is with you as our patient, not the insurance company. Our office is not a party to that contract and final responsibility of payment is yours. As a courtesy to you, we will help you process your insurance claims. If there is no payment from the insurance company within sixty (60) days, you will be expected to pay the balance in full.

Your portion of the payment is due at the time that services are rendered. We accept cash, money orders, personal checks, Visa, MasterCard, American Express and Discover. We also offer no interest and low interest extended payment plans through Care Credit.

Returned checks for any reason, will be assessed a processing fee of $25.00. Balances older than 60 days are subject to collection fees and finance charges at the rate of 18% annually. NOTE: 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 and collection costs.

Missed appointments without 24 hours notice are subject to a charge of $50.00.

I have read the above statement of the Financial Agreement and Policies, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account.

Signature_____Date_____

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HIPAA - ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. If you have any questions or concerns regarding the notice, please ask to speak with our HIPAA Compliance Manager.

Printed Patient Name: _____

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practices document.

_____ _____
Signature of patient or patient's representative Date

_____
Printed name of patient or patient's representative

_____
Relationship to patient

For Program Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____