Welcome

Thank you in advance for your coming to see us today. In order for us to better serve you, please take a few moments to complete this entire form. At Smile Oswego Dental, we are committed to keeping your private healthcare information confidential.

Today's Date:____/____/____

Name:_____

Prefer to be called:_____

☐ Male ☐ Female Birthdate:_____/_____/_____

Social Security #:_____

Driver's License #:_____

Address:_____

City_____OR____Zip_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home#:( )_____

Cell#:( )_____

Work:( )_____Ext._____

Employer:_____

Occupation:_____

Email:_____

Whom may we thank for referring you?_____

_____

Person Responsible for Account:_____

_____

Spouse Name:_____

Birthdate:_____/_____/_____

Employer:_____

Phone#:( )_____

In the event of an emergency, whom should we call?

Name:_____

Phone#:( )_____

Relation:_____

Primary Insurance Info: ☐ Yes ☐ No

Ins.Company Name:_____

Phone#:( )_____

Address:_____

ID#:_____Group#_____

Relationship to Patient:_____

Subscriber Name:_____

Subscriber Birthdate:_____/_____/_____

Subscriber Employer:_____

Secondary Insurance Info: ☐ Yes ☐ No

Ins.Company Name:_____

Phone#:( )_____

Address:_____

ID#:_____Group#_____

Relationship to Patient:_____

Subscriber Name:_____

Subscriber Birthdate:_____/_____/_____

Subscriber Employer:_____

Additional Family Members:

Name:_____

Birthdate:_____/_____/_____ ☐ Male ☐ Female

Name:_____

Birthdate:_____/_____/_____ ☐ Male ☐ Female

Name:_____

Birthdate:_____/_____/_____ ☐ Male ☐ Female

Health History

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.

Name:_____

Birthdate:_____/_____/_____

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:_____

Phone#:( )_____

Your current physical health is:

☐Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?

☐Yes ☐ No

Please explain:_____

_____

Do you smoke or use tobacco in any other form?

☐Yes ☐ No

Have you ever had a blood transfusion?

☐Yes ☐ No

Have you ever taken PhenPhen/Fosamax?

☐Yes ☐ No

Are you taking any prescription or over-the-counter drugs? ☐Yes ☐ No

If yes, please list each one:_____

_____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin
Y N Codeine Y N Barbiturates Y N Seasonal
Y N Jewelry Y N Sulfa Drugs Y N Latex
Y N Dental Anesthetics
Y N Other:_____

Please list additional drugs that cause allergic reactions:_____

For Women:Are you taking birth control?☐Yes ☐ No

Are you pregnant?☐Unsure ☐Yes, week #_____ ☐ No

Are you nursing? ☐Yes ☐ No

Please list any hospitalizations or major surgeries ☐Yes ☐ No in the last five years:_____

_____

_____

Have you experienced the following diseases or medical conditions?

Y N Abnormal Bleeding
Y N Alcohol Abuse/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Heart Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Colitis/Ulcers
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Frequent/Severe Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hepatitis Type___
Y N Herpes/Fever Blisters
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Venereal Disease

List any serious medical condition(s) that you have experienced (not listed):_____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is in my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

Dental History

Why did you come to the dentist today?_____

_____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

When was your last cleaning?_____

Did you have xrays at that time? ☐ Yes ☐ No

How often do you: Brush_____ Floss_____

Type of bristles on your toothbrush? (Circle)

Hard Medium Soft

Do you do anything else to clean your teeth? ☐ Yes ☐ No

If yes, what?_____

Do your gums bleed? ☐ Yes ☐ No

Have you ever had gum disease? ☐ Yes ☐ No

Have you ever had root planning or a deeper cleaning? ☐ Yes ☐ No

Does food get caught between your teeth? ☐ Yes ☐ No

Have you ever experienced problems associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Are you aware of any clenching or grinding? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you have any problems eating certain foods?

☐ Yes ☐ No If yes, what?_____

Are your teeth sensitive to hot, cold or anything else?

_____

Do you still have your wisdom teeth? ☐ Yes ☐ No

Do you have any mobility in your teeth? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

If yes, why?_____

If you could change one thing about your smile what would that be?_____

_____

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials:_____Date:_____

Doctor's Comments:_____

_____

_____

Medical History Update:

1. Date:_____ Comments:_____ Signature:_____

2. Date:_____ Comments:_____ Signature:_____

3. Date:_____ Comments:_____ Signature:_____

4. Date:_____ Comments:_____ Signature:_____

5. Date:_____ Comments:_____ Signature:_____

6. Date:_____ Comments:_____ Signature:_____

7. Date:_____ Comments:_____ Signature:_____

8. Date:_____ Comments:_____ Signature:_____

Marcus D. Uchida, DMD
Fadi B. Ibsies, DMD
17510 Provost St., Ste.205 Lake Oswego, OR 97034
Phone: 503-765-5555

PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION.

Authorization and Release

If you have dental insurance, we will prepare and submit your dental claims as a courtesy to you.

Payment is due in full at time of treatment
unless prior arrangements have been approved.

I acknowledge that I am financially responsible for all changes whether or not they are covered by insurance. I hereby authorize payment directly to Smile Oswego Dental of the group insurance benefits otherwise payable to me. I also authorize release of any information including this diagnosis and records of treatment or examination rendered to my insurance company. 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 rebilling and interest charges, missed appointment fees, all collection costs and reasonable attorney fees. Any accounts sent for collections will be assessed an additional $100 processing fee.

We appreciate your keeping your scheduled appointments. We reserve time and expertise exclusively for you because you are important to us. If you should need to change or cancel your appointment, we kindly ask that you give 48 hours notice. Appointments cancelled without 48 hour notice or failed appointments may be assessed a fee of $25 per half hour of scheduled time.

Payment plans and special arrangements must be made ***prior*** to treatment and approved by our office manager. Returned checks will be charged a flat rate of $25.00 per check per incident. Balances older than 60 days from the date of service, regardless of insurance, may be subjected to the following interest charges. Interest is calculated at a rate of 1.5% per month (or 18% annually or a $5.00 rebilling fee (whichever is greater)) and applied monthly to unpaid account balances.

For your convenience, we accept most major credit cards. We also offer additional payment plans through an outside financing group. If you would like more information or have any questions, please let us know. We are happy to help.

Name (Please Print)_____

Signature:_____**Date**:_____

Fadi Ibsies, DMD
Marcus Uchida, DMD
17510 Provost St., Ste.205
Lake Oswego, OR 97034
Phone: 503-765-5555

Smile Oswego Dental
Family Dental Care

Hipaa Consent for use/disclosure of Health Information

Notice: Smile Oswego Dental staff are committed to maintaining the confidentiality of your personal, financial and health information. We are required by applicable federal and state laws to maintain the privacy of your personal health information. We are also required to give you this notice. This notice took effect in April 2003 and will remain in effect until we replace it.

Consent: By signing this form, you consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge that you are aware of our needs to share information and received your rights notification explaining in detail our office policy and information sharing policy.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notification. We will honor the request from the day we received your written notification. Please understand that it will not affect any action taken before we received the revocation and we may decline to treat you or continue treating you if you revoke this consent.

Changes to Privacy Policies: We reserve the right to change our privacy policies described in our office patient right privacy policy and information practices. If we do change our practices, we will make available a revised patient and information privacy update statement.

Patient Responsibility: We request that you provide notification to us of any changes in your personal information we maintain for you in a timely manner.

Contact Information: You may obtain a copy of Notice of Privacy Practices by contacting Dr. Ibsies at (503)607-2222 or mailing us your request in writing to :
Smile Linn Dental Attn: Dr. Ibsies 18750 Willamette Dr. Suite B2 West Linn, OR 97062

I,_____ have received a copy of this office's Notice of Privacy Practices. I also agree to give my consent to Dr. Marcus Uchida DMD & staff to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Patient Name:_____Patient Signature:_____
Responsible Party Name:_____Relationship to patient:_____
Responsible Party Signature:_____Date:_____

For Office Use Only: We attempted to obtain a written acknowledgement of Receipt of Notice of Privacy Policy and Information Practices but it could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier kept us from obtaining acknowledgement
_____ An emergency situation kept us from obtaining acknowledgement
_____ Other_____