

## ADULT DENTAL HISTORY

1. Purpose of initial visit? \_\_\_\_\_
2. Are you aware of any dental problems?..... YES NO  
If yes, please explain \_\_\_\_\_
3. How long since your last dental visit? \_\_\_\_\_
4. What was done at that time? \_\_\_\_\_
5. What is your previous dentist's name? \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (     ) \_\_\_\_\_
6. Have you made regular visits to a dentist?..... YES NO  
How often? \_\_\_\_\_
7. Were dental x-rays taken?..... YES NO
8. Have you lost any teeth?..... YES NO  
Why? \_\_\_\_\_
9. Have any lost teeth been replaced?..... YES NO
10. How have these teeth been replaced?  
Fixed bridge (When: \_\_\_\_\_ )  
Removable bridge (When: \_\_\_\_\_ )  
Denture (When: \_\_\_\_\_ )
11. Are you happy with the replacement(s)?..... YES NO  
If no, explain \_\_\_\_\_
12. Have you ever had any problems with previous dental treatment?..... YES NO  
If yes, explain \_\_\_\_\_
13. Do you clench or grind your teeth?..... YES NO
14. Does your jaw click or pop?..... YES NO
15. Do you have pain or soreness in the muscles of your face or around your ear?..... YES NO
16. Do you have frequent headaches, neck aches or shoulder aches?..... YES NO
17. Does food get caught between your teeth?..... YES NO
18. Circle any of the following that your teeth are sensitive to:  
hot            cold            sweets            pressure
19. Do your gums bleed or hurt?..... YES NO  
When? \_\_\_\_\_
20. How often do you brush your teeth? \_\_\_\_\_ When? \_\_\_\_\_
21. Do you use dental floss?..... YES NO  
How often? \_\_\_\_\_
22. Are any of your teeth loose, tipped, or shifted?..... YES NO
23. Do you have any discolored teeth that bother you?..... YES NO
24. Do you feel your breath is offensive at times?..... YES NO
25. Have you ever had gum treatment or surgery?..... YES NO  
When? \_\_\_\_\_
26. Do you feel good about your teeth in general?..... YES NO
27. Are you happy with the appearance of your teeth?..... YES NO
28. Have you had any unpleasant dental experiences?..... YES NO
29. List anything about dentistry that you strongly dislike: \_\_\_\_\_
30. Do you have any dental questions or concerns?..... YES NO

**Doctor's Notes**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

**ANEST.**

**MED. ALERT**



## **FINANCIAL RESPONSIBILITY**

The doctors and all of our staff are committed to giving you superior dental care and we want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan, as well as our financial policy. Carefully read the following, then let us know if you have further questions...

Many people think if they have an employer provided benefit plan (insurance), it is the benefit plan that owes the doctor for their services. This is not the case. The benefit plan contract is between the patient, the employer, and the benefit plan company. As a courtesy to our patients, we'll bill your benefit plan, however, the responsibility for payment will remain with you. In order for us to bill your benefit plan, you must supply us with complete information about your benefit plan, including any necessary forms, group numbers, phone numbers, and addresses.

Most dental benefit plans do not cover 100% of the cost of your treatment. Patients are expected to pay the estimated non-covered portion at the time of service. If your benefit plan has not paid within 60 days of treatment, you will need to pay your account in full to this office. We will then reimburse you if and when your benefit plan has paid. This office can make no guarantees of the benefit plan's estimate of payment. This office does not absolve the patient of full responsibility for the charges in full for treatment rendered.

An often misunderstood term used by many dental benefit companies is "Usual, Customary and Reasonable Fee Schedule (UCR)." This is an arbitrary fee ceiling at which the benefit plan will stop reimbursement. After this ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee we charged, but with the level of coverage negotiated by the employer and benefit plan company.

Patients who do not participate with a benefit plan are expected to pay fees at the time of service unless prior arrangements have been made.

Our fees are on file with Oregon Dental Service.

We accept Visa, MasterCard, Discover, cash or check.

All accounts over 90 days will be assessed 1.5% interest per month (18% APR).

Delinquent accounts will be referred to a collection agency at the discretion of the office manager.

There may be a fee charged for all returned checks.

If unable to keep your appointments, kindly give us 48 hours notice. Otherwise, we reserve the right to charge for time reserved.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

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Patient's Signature (or Responsible Person, if patient is a minor)

Date

# ADULT MEDICAL HISTORY

1. Your physician's name, phone, address \_\_\_\_\_
2. Have you ever had a serious illness or operation?..... YES NO  
If yes, explain \_\_\_\_\_
3. When was your last complete physical exam? \_\_\_\_\_
4. Are you currently being treated/monitored for a specific condition by your physician?... YES NO  
If yes, why? \_\_\_\_\_
5. Are you taking any medication, including birth control?..... YES NO  
Please list: \_\_\_\_\_
6. Do you have any known allergies?..... YES NO
7. Are you allergic to any specific medications or substances?..... YES NO
8. Do you have any problem with penicillin, antibiotics, or anesthetics?..... YES NO
9. Have you been treated for or have you been told you might have heart disease?..... YES NO
10. Have you ever had a stroke?..... YES NO
11. Do you have a pacemaker or an artificial heart valve?..... YES NO
12. Are you aware of any heart murmurs?..... YES NO
13. Have you ever had rheumatic fever?..... YES NO
14. Have you ever been advised to be premedicated with antibiotics prior to dental treatment?..... YES NO
15. Have you ever had surgery, radiation treatment, or chemo therapy treatment for a tumor, growth, or other condition?..... YES NO
16. Do you have high or low blood pressure?..... YES NO
17. Do you have inflammatory diseases, such as arthritis, rheumatism, or lupus?..... YES NO
18. Do you have any artificial joints or prosthesis?..... YES NO
19. Do you have any blood disorders, such as anemia, leukemia, etc.?..... YES NO
20. Have you ever bled excessively after being cut or injured?..... YES NO
21. Do you have any stomach problems?..... YES NO
22. Do you have any kidney problems?..... YES NO
23. Do you have any liver problems?..... YES NO
24. Are you diabetic, or borderline diabetic?..... YES NO
25. Do you have asthma?..... YES NO
26. Do you have epilepsy or seizure disorders?..... YES NO
27. Have you ever had venereal disease?..... YES NO
28. Do you have AIDS or have you tested positive for HIV?..... YES NO
29. Have you ever had hepatitis?..... YES NO  
If yes, what type? \_\_\_\_\_
30. Have you ever had a blood transfusion?..... YES NO
31. Have you ever had TB?..... YES NO
32. Do you use any tobacco products?..... YES NO  
What type of product & how much? \_\_\_\_\_ For how long? \_\_\_\_\_
33. Do you consume alcoholic beverages?..... YES NO
34. Are you pregnant or suspect that you may be?..... YES NO
35. Do you have any disease, condition, or problem not listed?..... YES NO  
If yes, explain \_\_\_\_\_
36. Is there anything else we should know about your health that we have not covered?.... YES NO  
If yes, explain \_\_\_\_\_
37. Would you like to speak to the Doctor privately about any concerns?..... YES NO

**Doctor's Notes**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

\_\_\_\_\_  
Patient's Signature Date

\_\_\_\_\_  
Dentist's Signature Date

**ANEST.**

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Raleigh Park  
Dental Care

## **AUTHORIZATION & DISCLOSURE (HIPAA)**

**Truth-In-Lending Disclosure:** In accordance with the Federal Truth-In-Lending Act, we are providing the following information about our credit and fee policy:

1. Patient Portion is due at the time of service.
2. Balances extended beyond 90 days from date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%).
3. There may be a fee charged for cancellations with less than 48 hours notice.
4. There may be a fee charged for all returned checks.

**Assignment of Insurance Benefits:** I hereby authorize Raleigh Park Dental Care to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to Raleigh Park Dental Care.

**Authorization to Release Information:** I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

**Financial Responsibility:** I understand that it is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the dental services received.

**Authorization to Perform Procedures:** I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

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Print Full Name (Patient or Responsible Person, if patient is a minor)

Date of Birth

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Signature

Date

Authorization valid until specifically revoked in writing.

# NEW PATIENT REGISTRATION

## Welcome!

Thank you for choosing Raleigh Park Dental Care.

We are committed to providing every adult and child with the highest quality oral healthcare in the most gentle, efficient manner possible. Remember, the more we know about you, the better we can help you reach and maintain your goals.

**Instructions:** Please complete these Registration forms to the best of your knowledge. Then bring the completed and signed forms with you on your next appointment. Or, visit us at [www.rpdentalcare.com](http://www.rpdentalcare.com) to complete them online.

Thank you!

YOU MAY WANT TO MAKE COPIES OF THESE FORMS FOR YOUR FILES.

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_  
Last First Initial

Preferred Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Parent's/Guardian's Name (if child under age 18):

\_\_\_\_\_ Last First Initial

Which of the following describe(s) your current status?

- Single       Married       Separated  
 Divorced       Widowed       Minor

Home Address/PO Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #1: (    ) \_\_\_\_\_

Phone #2: (    ) \_\_\_\_\_

Email Address \_\_\_\_\_

Work Address/PO Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (    ) \_\_\_\_\_ Ext.# \_\_\_\_\_

Patient/Parent Employed by \_\_\_\_\_

Present Position \_\_\_\_\_ How long held \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Spouse Employed by \_\_\_\_\_

Present Position \_\_\_\_\_ How long held \_\_\_\_\_

Responsible Party for this account \_\_\_\_\_

Responsible Party Social Security # \_\_\_\_\_

Method of Payment:  Ins. Co-payment     Credit Card     Cash

Purpose of this visit \_\_\_\_\_

Other family members who are patients here:

\_\_\_\_\_

\_\_\_\_\_

## DENTAL INSURANCE 1st COVERAGE

Employee Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone (    ) \_\_\_\_\_

Group # \_\_\_\_\_

## DENTAL INSURANCE 2nd COVERAGE

Employee Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone (    ) \_\_\_\_\_

Group # \_\_\_\_\_

Whom may we thank for this referral? \_\_\_\_\_

### **In case of emergency, please notify:**

Closest family member (Name/Phone):

\_\_\_\_\_

\_\_\_\_\_

Family or friend not living in same house (Name/Phone):

\_\_\_\_\_

\_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

\_\_\_\_\_  
Patient's Signature (or Responsible Person, if patient is a minor)

\_\_\_\_\_  
Date

# CHILD DENTAL & MEDICAL HISTORY

## DENTAL HISTORY

- |  |     |    |
|--|-----|----|
| 1. Is this the child's first visit to a dentist?.....                        | YES | NO |
| If no, how long since the child's last visit? _____                          |     |    |
| 2. Does the child eat between meals?.....                                    | YES | NO |
| 3. Does the child eat sweets, such as candy, soda pop or chewing gum?.....   | YES | NO |
| 4. Does the child eat well-balanced meals?.....                              | YES | NO |
| 5. Who brushes the child's teeth? _____                                      |     |    |
| How often? _____   |     |    |
| 6. Do you live in an area without fluoridated water?.....                    | YES | NO |
| 7. Have teeth been treated with fluorides?.....                              | YES | NO |
| 8. Have any cavities been noted in the past?.....                            | YES | NO |
| 9. Were any teeth (baby or permanent) removed by extraction?.....            | YES | NO |
| Was it suggested that the space be maintained?.....                          |     |    |
| Was a space-maintaining appliance placed?.....                               |     |    |
| 10. Have teeth suffered any traumas from falls or blows, etc.?.....          | YES | NO |
| If so, please describe _____   |     |    |
| _____  |     |    |
| 11. Has the child had any unfavorable dental experience?.....                | YES | NO |
| 12. Has anyone in the family, including parents, had braces?.....            | YES | NO |
| 13. Has the child ever received a local anesthetic?.....                     | YES | NO |
| 14. Has the child ever had occlusal sealants (to prevent dental decay)?..... | YES | NO |

## MEDICAL HISTORY

- |   |   |    |
|---|---|----|
| 1. Is the child in good health?.....  | YES                                       | NO |
| 2. Is the child currently being treated/monitored for a specific condition by a physician?.....         | YES                                       | NO |
| If yes, how long and why? _____   |   |    |
| 3. Name of the physician: _____   |   |    |
| Telephone: (     ) _____  |   |    |
| 4. Has the child had any serious illness?.....  | YES                                       | NO |
| What? _____   |   |    |
| When? _____   |   |    |
| 5. Has the child had surgery?.....  | YES                                       | NO |
| 6. Is surgery being contemplated?.....  | YES                                       | NO |
| 7. Is the child subject to profuse bleeding?.....   | YES                                       | NO |
| 8. Is the child subject to nervous disorders?.....  | YES                                       | NO |
| 9. Is the child subject to fainting or dizziness?.....  | YES                                       | NO |
| 10. Does the child have any allergies?.....   | YES                                       | NO |
| 11. Is the child allergic to penicillin, antibiotics or other drugs?.....                               | YES                                       | NO |
| 12. Is the child receiving any medication?.....   | YES                                       | NO |
| If yes, please list: _____  |   |    |
| 13. Has the child ever been advised to be premedicated with antibiotics prior to dental treatment?..... | YES                                       | NO |
| 14. The child has had a history of (please check):  |   |    |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Kidney Infection |    |
| <input type="checkbox"/> Heart Trouble  | <input type="checkbox"/> Rheumatic Fever  |    |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Ear Infection    |    |

### Doctor's Notes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of Responsible Person _____	Date _____
Dentist's Signature _____	Date _____

**ANEST.**

**MED. ALERT**