133 E Main Street, Carlton, OR 97111 Phone: (503) 852-7147

PATIENT REGISTRATION & HEALTH HISTORY FORM

Date: _____

PATIENT INFORMATION

First Name: _____ M: _____

Last Name: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Gender: _____ Is the patient a minor? Yes ☐

Relationship Status: Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed ☐

Is the patient a student? Full Time ☐ Part Time ☐

Employer: _____

Phone: _____

Occupation: _____

Employer Address: _____

_____

Spouse's Name: _____

Date of Birth: _____

How did you hear about us?: _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Subscriber ID/SSN: _____

Is patient covered by additional insurance? Yes ☐ No ☐

Subscriber's Name: _____

Date of Birth: _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Subscriber ID/SSN: _____

ASSIGNMENT AND RELEASE. I certify that I, and/or my dependents have insurance coverage with _____ and assign directly to Carlton Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name dental practice may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

CONTACT INFORMATION *REQUIRED INFORMATION*

*Cell Phone (____)_____ Is it okay to send text messages for appointment confirmations and reminders? Yes ☐ No ☐

*Email Address: _____ This is used for appointment reminders/confirmations. This is never used for spam or given out to anyone else.

Home Phone (____) _____ Work Phone (____) _____ Best time and place to reach you: _____

Emergency Contact: Name _____ Relationship _____ Phone (____) _____

DENTAL HISTORY

Reason for today's visit: _____

_____

Date of last dental visit: _____

Date of last dental X-rays: _____

	Yes	No
Do you have bleeding gums?	☐	☐
Do you use any form of tobacco?	☐	☐
Do you have dry mouth?	☐	☐
Does food collect between your teeth?	☐	☐
Do you grind your teeth?	☐	☐
Any loose teeth or fillings?	☐	☐
Do you have any jaw pain?	☐	☐

SMILE EVALUATION

	Yes	No
Would you like your teeth to be straighter?	☐	☐
Would you like your teeth to be whiter?	☐	☐
Have you noticed any wear or chipping of your teeth?	☐	☐

If there is anything you could change about your teeth, what would it be?

_____

SLEEP HEALTH

	Yes	No
Do you snore?	☐	☐
Do you wakeup not feeling refreshed?	☐	☐
Do you wakeup in the morning with headaches?	☐	☐
Is it hard to stay awake during the day?	☐	☐

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HEALTH HISTORY

Yes	No	
☐	☐	AIDS/HIV
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	Arthritis, Rheumatism
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Blood Disease
☐	☐	Cancer
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Circulatory Problems
☐	☐	Cortisone Treatments
☐	☐	Diabetes
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting or dizziness
☐	☐	Glaucoma
☐	☐	Headaches
☐	☐	Hepatitis Type _____

Yes	No	
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Jaundice
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Nervous System Problems
☐	☐	Psychiatric Care
☐	☐	Radiation Treatment
☐	☐	Respiratory Disease
☐	☐	Shortness of Breath
☐	☐	Sinus Trouble
☐	☐	Swollen Neck Glands
☐	☐	Thyroid Problems
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Tumor or growths on head
☐	☐	Ulcer

Yes	No	
☐	☐	Artificial Heart Valves
☐	☐	Artificial Joints
☐	☐	Abnormal Bleeding After Surgery
☐	☐	Congenital Heart Lesions
☐	☐	Heart Murmur
☐	☐	Mitral Valve Prolapse
☐	☐	Pacemaker
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Stroke
☐	☐	Premedication needed for dental visits?
☐	☐	Are You Pregnant?

Other Heart Problems: _____

_____

_____

Other Medical Conditions: _____

_____

_____

MEDICATIONS

Please list any medications that you are currently taking:

_____

_____

_____

_____

_____

Physician Name: _____

Physician Location: _____

Physician Phone: _____

ALLERGIES

	Yes	No
Penicillin or other antibiotics	☐	☐
Aspirin	☐	☐
Codeine or other narcotics	☐	☐
Lodine	☐	☐
Latex	☐	☐
Local Anesthetic	☐	☐
Sulfa Drugs	☐	☐
Reaction to metals	☐	☐

Other/Details: _____

_____

The undersigned hereby authorizes the doctors and staff at Carlton Dental to perform dental exams, take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors at Carlton Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the use of anesthetics and understand that use of anesthetics embodies a certain risk.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Sign here: _____ Date: _____

Doctor: _____ Date: _____

CARLTON
DENTAL

LATE AND MISSED APPOINTMENT POLICY

At Carlton Dental, our goal is to provide quality dental care. To do this it requires a time commitment from you as well as from us. When you reserve an appointment, you will have our time and attention as well as materials and equipment setup just for you.

If for any reason your appointment must change, it is important that you give our office **at least 48 hours notice** to avoid a $25 rescheduling fee.

I have read the policy above. I understand and agree to abide by the listed terms.

_____ _____

Signature of Financially Responsible Party Date

INSURANCE AND FINANCIAL POLICY

Thank you for choosing Carlton Dental for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need.

- **Payment for services is required at the time service is provided**. Accepted forms of payment include Cash, Checks, Visa, MasterCard, American Express, Discover and Care Credit.

- **Insurance patients:** Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

  We currently accept most insurance plans. This means that we work with **literally hundreds of companies**. Although we maintain computerized histories of payment by a given company, **they do change**; therefore it is **NOT possible** to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. Insurance companies do not provide us with accurate charges for any procedures.

- We bill your insurance company as a courtesy to you. If your insurance does not pay within 60 days, **Carlton Dental** reserves the right to request payment from you, in full, for services provided and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU** and **your insurance company**. Our office is not, and cannot be a part of that legal contract. **Ultimately, you are responsible for all charges incurred in our office.**

- **Patients without insurance:** Payment is required **in full at the time of service**. We understand that without dental insurance it can be difficult especially if there are extensive dental needs. Please consult with our treatment coordinator for payment options including 3rd party financing options such as Care Credit.

- **Minor Patients:** The adult accompanying a minor and the parents (or guardians) are responsible for **full payment,** regardless of court child support order. For unaccompanied minors, non-emergency treatment will not be done unless prior approval and financial arrangements have been made.

- **Emergency Visits:** In the event of an **emergency** after regular business hours a $55 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $125 for an after hours emergency fee.

- **Financial Arrangements:** I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of my account owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. Any returned check will be assessed a $35 fee no further checks will be accepted from that patient. If the account should be turned over to a collection agency, for any reason, 10% of the principle balance will be added for interest along with an additional 10% service charge.

I have read the insurance and financial policy above. I understand and agree to abide by the listed terms.

_____ _____

Signature of Financially Responsible Party Date

CARLTON DENTAL

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.
Please review it carefully.
The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating

practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on a Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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