NEW PATIENT REGISTRATION

Welcome!

Thank you for choosing GLADSTONE FAMILY DENTISTRY!
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.GladstoneFamilyDentistry.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

GLADSTONE FAMILY DENTISTRY 1105 Portland Avenue, Gladstone, OR 97027
503-657-3077 • *Fax:* 503-655-5729 • GladstoneFamilyDentistry.com

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized or had surgery? (Please circle) No Yes
If yes: Why and When _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Abnormal bleeding from a cut? Blood Disorder?	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes
Asthma, COPD, Emphysema or other lung diseases?	No	Yes
Autoimmune or Immune Suppression?	No	Yes
Bacterial Endocarditis?	No	Yes
Cancer, Tumor, Chemotherapy, Radiation Treatment?	No	Yes
Diabetes? If yes what was your last A1C?	No	Yes
Fainting or Dizzy Spells?	No	Yes
Heart Condition or Stroke?	No	Yes
High Blood Pressure?	No	Yes
Joint Replacement? Is Pre-Medication Required?	No	Yes
Kidney Disease? Renal Dialysis?	No	Yes
Liver Disease, Hepatitis (including Jaundice)?	No	Yes
Sore or Enlarged Lymph Nodes	No	Yes
STD, HIV, AIDS, Venereal Disease?	No	Yes
Have you ever been diagnosed with a disease or disorder that affects your immune system?	No	Yes
Recurrent Illnesses or other Condition? Please List	No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 2. _____

3. _____ 4. _____

(PLEASE CONTINUE TO PAGE 2)

Do you have a family history of: any the following conditions:

Diabetes.....	No	Yes
Heart Disease.....	No	Yes
Periodontal (Gum) Disease.....	No	Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics or epinephrine.....	No	Yes
b. Penicillin or other antibiotics	No	Yes
c. Aspirin, Ibuprofen or Tylenol®	No	Yes
d. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives.....	No	Yes
e. Latex or Metals.....	No	Yes
f. Other (please specify)_____		
Have you ever been treated with Bisphosphonate drugs (Fosamax, RECLAST, Boniva, Prolia)	No	Yes
Have you been told you snore while sleeping?	No	Yes
Have you been diagnosed with Sleep Apnea? Do you snore? Use a C-Pap?	No	Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Have you ever used tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed (including: marijuana, vaping, edibles, tinctures, etc) ? Frequency? For how long?	No	Yes

WOMEN ONLY:

Are you currently pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?.....	No	Yes
Are you a nursing mother?	No	Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)	**Patient Signature**	**Date**
Doctor (Print Name)	***Doctor Signature***	***Date***

Gladstone Family Dentistry
1105 Portland Ave., Gladstone, OR 97027
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gladstonefamilydentitsty.com

Adult Dental History

Name_____ Date of Birth_____
Print Name

1. Purpose of initial visit? _____
2. How long since your last dental visit? _____
3. What was done at that time? _____
4. What is your previous dentist's name? _____
5. Have you made regular visits to a dentist? ..... YES NO
   How often? _____
6. Have you lost any teeth? ..... YES NO
7. Have they been replaced? ..... YES NO
8. How have they been replaced?
   A. Implant ..... YES NO
   B. Fixed Bridge ..... YES NO
   C. Removable Appliance (Partial, Denture) ..... YES NO
   Are you happy with the replacement? ..... YES NO
   If no, please explain _____
9. Are you aware of any clenching or grinding of your teeth ..... YES NO
10. Does your jaw click or pop? ..... YES NO
11. Does food get caught between you teeth? ..... YES NO
12. Are any of your teeth sensitive to: (circle) hot cold sweets pressure/chewing
13. Do your gums bleed or hurt? ..... YES NO
    When? _____
14. How often do you brush your teeth? _____ When? _____
15. Do you use dental floss? How often? ..... YES NO
16. Are any of your teeth loose, tipped or shifted? ..... YES NO
17. Do you have any discolored teeth that bother you? ..... YES NO
18. Do you feel your breath is offensive at times? ..... YES NO
19. Have you ever been told you have periodontal (gum) disease? ..... YES NO
    If yes, have you ever had periodontal (gum) surgery or treatment? ..... YES NO
    When? _____
20. Do you have a history of cold sores, oral lesions, or slow healing mouth sores? ..... YES NO
21. How do you feel about your teeth in general? _____
22. Are you happy with the appearance of your teeth? ..... YES NO
23. Have you had any unpleasant dental experiences? ..... YES NO
24. List anything about dentistry that you strongly dislike: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE_____ DATE_____

DENTIST'S SIGNATURE_____ DATE_____

ANEST.

MED. ALERT

Gladstone Family Dentistry
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GLADSTONE
FAMILY DENTISTRY

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, American Express, cash or check.

All accounts over 60 days will be assessed 1.5% interest per month (18% APR).

There will be a $25.00 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 $35.00 for time reserved.

You will need to provide our office with your Social Security number and health insurance card (if applicable) unless your total charge is paid in cash at the time of service. Treatment may be postponed if the above are not furnished by the patient or responsible party.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections on any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the office to release information necessary to secure payment.

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

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GLADSTONE
FAMILY DENTISTRY

AUTHORIZATION & DISCLOSURE (HIPAA)

CREDIT POLICY & FEES DISCLOSURE
ASSIGNMENT OF INSURANCE BENEFITS
AUTHORIZATION TO RELEASE INFORMATION
FINANCIAL RESPONSIBILITY

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 60 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 will be a $30.00 fee charged for cancellations with less than 24 hours notice.
4. There will be a $25.00 fee charged for all returned checks.

Assignment of Insurance Benefits: I hereby authorize GLADSTONE FAMILY DENTISTRY to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to GLADSTONE FAMILY DENTISTRY.

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.

Print Full Name (Patient or Responsible Person, if patient is a minor) _____ Date of Birth _____

Signature _____ Date _____

Authorization valid until specifically revoked in writing.

RESERVED APPOINTMENT AGREEMENT

FOR **GLADSTONE FAMILY DENTISTRY**

We make every effort to value your time and we schedule your appointment time just for you.

It is our philosophy to continue to put our patients first and to make your experience a positive one.

It is our policy for our patients to give us 2-business days notice if you need to change your appointment, and for you to call and speak directly with the staff members to best manage your appointment change.

At **Gladstone Family Dentistry** we want to avoid any additional charges to your account. Our office policy is to apply a charge to a patients account for not honoring rescheduling any appointment within 2 business days. The fee is based on the length of time our office has reserved for you. Our office is intentional about providing support to all our patients by providing courtesy confirmation options. At **Gladstone Family Dentistry** we provide confirmations by text, email, and by phone. Most of our confirmations are delivered 2 days prior to your appointment.

Thank you for allowing us to take the time to review our reserved appointment agreement with you and please let us know if you have any questions. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

How would you like to be contacted?

_____I would like to be provided a courtesy confirmation by email _____

_____ I would like to be provided a courtesy confirmation by Text #_____

_____I would like to be provided a courtesy confirmation by phone #_____

_____ I will partner **with Gladstone Family Dentistry** by responding to messages provided by them with a confirmation either by text, email, or phone. This will support us with holding your reserved appointment time.

I have read the above reserved appointment agreement for **Gladstone Family Dentistry** and agree to partner with helping manage my scheduled appointment times.

Patient Signature:_____Date:_____

Front Office Administrator Signature:_____