

NEW PATIENT REGISTRATION

Welcome!

Thank you for choosing Woodburn Community Dental.

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.woodburncommunitydental.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):

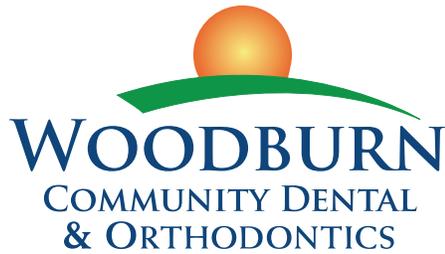
Family or friend not living in same house (Name/Phone):

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



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 Woodburn Community Dental to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to Woodburn Community Dental.

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.

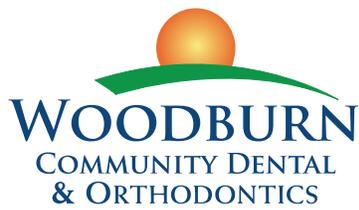
Print Full Name (Patient or Responsible Person, if patient is a minor)

Date of Birth

Signature

Date

Authorization valid until specifically revoked in writing.



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.

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?..... | YES | NO |
| Was a space-maintaining appliance placed?..... | YES | NO |
| 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