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

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**

WOODBURN
COMMUNITY DENTAL
& ORTHODONTICS

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.

WOODBURN
COMMUNITY DENTAL
& ORTHODONTICS

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):

- ☐ Diabetes
- ☐ Heart Trouble
- ☐ Asthma
- ☐ Kidney Infection
- ☐ Rheumatic Fever
- ☐ Ear Infection

Doctor's Notes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of Responsible Person Date

Dentist's Signature Date

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