PATIENT REGISTRATION

Referring Dentist_____

Patient's Name_____Nickname _____

Date of Birth_____Social Security #_____Gender_____

Mailing Address_____ City_____State_____Zip_____

Phone 1 _____ Cell / Hm/ Work Phone 2 _____ Cell / Hm / Work

Emergency Contact_____Relationship_____ Phone _____

Email address _____Employer_____

PAYMENT FOR OFFICE VISITS ARE DUE AT THE TIME OF TREATMENT.

Dental Insurance Information

Do you have **Dental** Insurance? Yes No Secondary Insurance? Yes No

Primary Insurance Company: _____

Subscriber Name _____ Birthdate: _____

Group name _____ Group #_____

Relationship to Subscriber: Self Spouse/Partner Child Member ID #_____

Secondary Insurance Company: _____

Subscriber Name _____ Birthdate: _____

Group name _____ Group #_____

Relationship to Subscriber: Self Spouse/Partner Child Member ID #_____

Financial Commitment

Dental insurance is a contract between the insurance company, you and your employer. Our expectations of you as the policy owner are:

1. Payment of co-payment, deductible, and/or fees not covered by your insurance plan are to be paid at the time service is provided.
2. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules, and exclude some procedures based on prior conditions or length of time of the plan.
3. Taking responsibility for payment if the insurance company does not pay our office within 75 days. All accounts over 90 days are subject to a 9% A.P.R. interest charge.
4. Keeping our office informed with accurate and current information of any changes in your insurance coverage.

If it becomes necessary to effect collections of amount, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

Assignment and Release:

"I understand that I am financially responsible for all dental services provided. I also authorize the release of my records or dental information as may be required."

Printed Name_____**Signature**_____**Date** _____

HEALTH HISTORY

Patient Name_____ **Birthdate** _____

I. CIRCLE APPROPRIATE ANSWER (please leave blank if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what?_____
   Date of last medical exam?_____ Physician Name/Phone_____
5. Yes No Are you allergic or sensitive to any medications, local anesthetics, or latex?
   Please list:_____

II. HAVE YOU EXPERIENCED: NO □

6. Yes No Chest pain (angina)?
7. Yes No Persistent cough, Coughing up blood?
8. Yes No Bleeding problems, Bruising easily?
9. Yes No Sinus problems/Seasonal allergies?
10. Yes No Frequent urination?
11. Yes No Excessive thirst?
12. Yes No Headaches?
13. Yes No Dry mouth?

III. DO YOU HAVE OR HAVE YOU HAD: NO □

14. Yes No Heart surgery/Artificial Heart Valve?
15. Yes No Heart attack?
16. Yes No Irregular Heartbeat/Pacemaker?
17. Yes No High Blood Pressure?
18. Yes No Arthritis/Rheumatism?
19. Yes No Artificial joint (hip, knee, other)?
20. Yes No Epilepsy/Seizures?
21. Yes No Asthma, TB, emphysema, other?
22. Yes No Hepatitis/Liver disease?
23. Yes No Stomach problems/Ulcers/Reflux?
24. Yes No Stroke?
25. Yes No HIV?
26. Yes No Cancer /Tumors?
27. Yes No Radiation/Chemotherapy?
28. Yes No Psychiatric care?
29. Yes No Thyroid/Adrenal disease?
30. Yes No Glaucoma?
31. Yes No Anemia?
32. Yes No Diabetes?
33. Yes No Herpes?
34. Yes No Kidney/Bladder disease?
35. Yes No TMJ/Popping/Clicking?

IV. ARE YOU TAKING: NO □

36. Yes No Antibiotics/Sulfa Drugs?
37. Yes No Aspirin/Advil/Motrin/Aleve?
38. Yes No Insulin/Oral Diabetic Medication?
39. Yes No High Blood Pressure Medication?
40. Yes No Bisphosphonates (Fosomax/Boniva/Actonel/Aredia/Zometa/Didronel/Skelid)?
41. Yes No Please list all Medications, Recreational Drugs, Over-The-Counter Medicines and Natural Remedies:

_____

_____

42. Yes No Inhaler/Asthma Medication?
43. Yes No Anticoagulants (Coumadin)?
44. Yes No Nitroglycerin?
45. Yes No Alcohol?
46. Yes No Tobacco?

V. WOMEN ONLY:

47. Yes No Are you or could you be pregnant?
48. Yes No Taking birth control pills?

VI. ALL PATIENTS:

49. Yes No Do you have or have you had any other diseases or medical conditions NOT listed on this form?
    If so, please explain_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Mitchell of any change in my health and/or medication.

Patient's Signature:_____ Date:_____

Corvallis Endodontics | 1811 NW Kings Blvd | Corvallis, OR 97330
Ross P. Mitchell, DMD LLC | John R. Wiens, DDS | (541) 758-0888

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1811 NW Kings Blvd
Corvallis, OR 97330
(541)758-0888

Name: _____ Date of Birth: _____

We are unable to discuss your treatment with anyone unless you give us written permission.

__ I authorize the release of information including the diagnosis, records, images, examination rendered to me, and claims information. In addition to my general dentist, this information may be released to:

__ Spouse Name: _____

__Child(ren) Name(s): _____

__ Parent(s) Name: _____

__ Other: _____

_____ Upon my request, I hereby authorize **Corvallis Endodontics** to email me my personal Health information through a non-secure email server.
_____ Information is not to be released to any party other than my Dentist/Doctor or Insurance company. This release of Information will remain in effect until terminated by me in writing. I have received a copy of the Notice of Privacy Practices.

Signed: _____ Date: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__Individual refused to sign __Emergency situation prevented us from obtaining prior acknowledgement __Other Staff: _____