Gates Family Dentistry of Wilsonville, PC

MEDICAL HISTORY

Patient Name: Parent/Guardian: Address:	City: State: Zip:	Date of Birth: Relationship to Patient: Best Contact #:	
Current Physician:		Physician's Contact #:	

Welcome to Gates Family Dentistry! Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry you will receive. All information is completely confidential.

	Yes	No
Have you had any medical care within the past two years? If Yes, please describe:		
Have you taken any medication or drugs during the past two years? If Yes, list name and dosage(s):		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If Yes, list name and dosage(s):		
Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? If Yes, list name and dosage(s):		
Are you aware of having an allergic (or adverse) reaction to any substance or medication? If Yes, please specify:		
Have you ever been hospitalized or had a major operation, in the past five years? If Yes, please describe:		
Do you use tobacco? (Including smokeless tobacco)		

Please indicate which of the following you have had, or presently have:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive			Cortisone Medicine			Hemophilia			Radiation Treatments		
Alzheimer's Disease			Diabetes			Hepatitis A			Recent Weight Loss		
Anaphylaxis			Drug Addiction			Hepatitis B or C			Renal Dialysis		
Anemia			Easily Winded			Herpes			Rheumatic Fever		
Angina			Emphysema			High Blood Pressure			Rheumatism		
Arthritis/Gout			Epilepsy or Seizures			High Cholesterol			Scarlet Fever		
Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Shingles		
Artificial Joint			Excessive Thirst			Hypoglycemia			Sickle Cell Disease		
Asthma			Fainting Spells/Dizziness			Irregular Heartbeat			Sinus Trouble		
Blood Disease			Frequent Cough			Kidney Problem			Spina Bifida		
Blood Transfusion			Frequent Diarrhea			Leukemia			Stomach/Intestinal Disease		
Breathing Problem			Frequent Headaches			Liver Disease			Stroke		
Bruise Easily			Genital Herpes			Low Blood Pressure			Swelling of Limbs		
Cancer			Glaucoma			Lung Disease			Thyroid Disease		
Chemotherapy			Hay Fever			Mitral Valve Prolapse			Tonsillitis		
Chest Pain			Heart Attack/Failure			Osteoporosis			Tuberculosis		
Cold Sores/Fever Blisters			Heart Murmur			Pain in Jaw Joints			Ulcers		
Congenital Heart Disease			Heart Pacemaker			Parathyroid Disease			Venereal Disease		
Convulsions			Heart Trouble/Disease			Psychiatric Care			Jaundice (Yellowing)		

WOMEN:	Yes	No		Yes	No
Are you pregnant or think you could be pregnant?			Nursing?		
Do you use birth control prescriptions?					

Doctor Verified: ____________________ Date: ____________________

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DENTAL HISTORY

Previous Dentist: Address:	City: State: Zip:	Dentist's Contact #:	

What is the reason for your visit today?

Date of Last Dental Visit: **Last Dental Cleaning:** **Last Full Mouth X-Ray:**

What was done at your last dental visit?

How often do you have dental examinations?

How often do you brush your teeth? How often do you floss?

Have you ever used or are currently using topical fluoride?

What other dental aids do you use? (Interplak, Toothpick, etc.)

Do you currently smoke or chew tobacco?

Do you have any dental problems now? If yes, please describe:

Are any of your teeth sensitive to:	Yes	No
Hot or Cold?	☐	☐
Sweets?	☐	☐
Biting or Chewing?	☐	☐
Have you noticed any mouth odor or bad tastes?	☐	☐
Do you frequently get cold sores, blisters or other oral lesions?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐
If yes, where:		

Do you:	Yes	No
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your lip or cheek regularly?	☐	☐
Hold foreign objects with your teeth? (pencil, pipe, etc)	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐
Snore or have and other sleeping disorder?	☐	☐
Smoke/chew tobacco or use other tobacco products?	☐	☐

Have you ever had:	Yes	No
Orthodontic treatments?	☐	☐
Oral surgery?	☐	☐
Periodontal treatments?	☐	☐
Your teeth ground or bite adjusted?	☐	☐
A bite plate or mouth guard?	☐	☐
A serious injury to the mouth or head?	☐	☐

Have you experienced:	Yes	No
Clicking or popping of the jaw?	☐	☐
Pain? (joint, ear, side of face)	☐	☐
Difficulty in opening or closing your mouth?	☐	☐
Difficulty in chewing on either side of the mouth?	☐	☐
Headache, neckache, shoulder aches?	☐	☐
Sore muscles? (neck, shoulders)	☐	☐

Other possible concerns:	Yes	No
Are you satisfied with your teeth's appearance?	☐	☐
Would you like to replace your silver fillings?	☐	☐
Would you like to keep all your teeth all of your life?	☐	☐

	Yes	No
Do you feel nervous about having dental treatments?	☐	☐
If Yes, please describe:		
Have you ever had an upsetting dental experience?	☐	☐
If Yes, please describe:		
Have you ever been told to take a pre-medication prior to dental treatment?	☐	☐
If Yes, please describe:		
Is there anything else about dental treatment that you would like to know?	☐	☐
If Yes, please describe:		

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PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Complete if this appointment is for you						
Date:						
Last Name		First		M.I.		
Called By						
Address						
City		State		ZIP		
Phone #		Fax #				
Cell #		Email				
Birthdate		Age		Male		Female
☐ Married	☐ Single	☐ Divorced	☐ Widowed			
SSN:						

Complete is this appointment is for your child						
Date:						
Last Name		First		M.I.		
Called By						
Address						
City		State		ZIP		
Phone #						
Birthdate		Age		Male		Female
School				Grade		
SSN:						

Dental Insurance – Primary Carrier	
Insurance Company	
Group Number	
Employer Name	
Insured's Name	
Date of Birth	
Relationship to Patient	
Insured's ID Number	
Insured's SSN	

Dental Insurance – Secondary Carrier	
Insurance Company	
Group Number	
Employer Name	
Insured's Name	
Date of Birth	
Relationship to Patient	
Insured's ID Number	
Insured's SSN	

Getting to know you….					
Is another member of your family or relative a patient at our office?					
Name					
Relationship					
Who were you referred to us by?					
Name					
Person to contact for emergency					
Name					
Cell #					
Home #					
Address					
City		State		ZIP	

Account Information					
Person financially responsible for account?					
Name					
Relationship					
SSN					
Address					
City		State		ZIP	
Phone #					
You…					
Name					
Occupation					
Employer					
Address		City			
Phone #		Fax			
Your Spouse…					
Name					
Occupation					
Employer					
Address		City			
Phone #		Fax			

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AUTHORIZATION TO RELEASE RECORDS/X-RAYS

The undersigned hereby authorize the release of any information relating to my dental, medical records and x-rays, on behalf of myself and/or dependents, in the possession of my dentist.

I further expressly agree and acknowledge that my signature on this document authorizes my Dentist to release records for services rendered to the person designated below.

Patient name:

Date of Birth:

Patient Signature: Date:

Gates Family Dentistry of Wilsonville

29990 SW Town Center Loop W., Suite A

Wilsonville, Oregon, 97070

Tel: (503) 682-2110

Fax: (503) 682-8951

Email: office@gatesdentistrywilsonville.com

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PRIVACY POLICY
(HIPAA ACKNOWLEDGEMENT)

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Gates Family Dentistry of Wilsonville Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Gates Family Dentistry of Wilsonville Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Patient Privacy Officer as indicated on your Notice.

Patient Name:

If Patient Representative, Name:

If Patient Representative, Relationship to Patient:

Account # or Medical Record #:

Signature:

Date Notice Received:

I give consent to discuss my treatment with:

relationship to patient

(Disclaimer: This form remains effective until patient informs us of any changes and fills out new form).

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CONSENT FORM (TREATMENT & PHOTO)

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of [ ] dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all ser1ices rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 /2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

6. **Cell Phone**: ☐ By checking this box, I consent to the dental practice using my cell phone number to (choose one or both) ☐ call and/or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdrawal my consent at any time.

   My cell phone number is (include area code):

7. I understand the medical and dental history 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 any change in my health or medication.

Photo Release Consent

Publication of Records. I authorize photos, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry or dental insurance documentation. My identity will not be revealed to the general public, however, without my permission. My initial identify I acknowledge this consent:

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Patient's Signature ______________________ Date ______________ Witness ______________________

Parent/Responsible Party's Signature ______________________ Relationship to Patient ______________________

PLEASE VERIFY ALL INFORMATION FOR ACCURACY. WHEN VERIFIED, PLEASE PRESS THE SUBMIT BUTTON BELOW TO SEND THIS DOCUMENT TO GATE'S FAMILY DENTISTRY OF WILSONVILLE

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Gates Family Dentistry Cancellation/No Show Policy

Thank you for trusting your dental care to Gates Family Dentistry. When you schedule an appointment, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Policy below:

- Any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least **24 hour notice** a **third** time will be considered a No Show and charged a **$50.00 fee**.
- If a **fourth** No Show with no 24 hour notice should occur the patient may be **dismissed** from Gates Family Dentistry.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patients next office visit.**
- As a courtesy, we make reminder calls, emails and text messages as a reminder for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Gates Family Dentistry 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message. Messages left are acceptable.

Gates Family Dentistry (503) 682-2110

I have read and understand the Dental Appointment Cancellation Policy and agree to its terms.

Printed Name:

Signature: Date:

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