Patient Number

PATIENT REGISTRATION

MED. ALERT

Welcome to our office. So that we may become better acquainted, please provide the following information:

Date of Birth: _____ Age:_____ Sex: M or F

Patient's
Name:_____
Last First Initial

If child,
Parent's Name:_____
Last First Initial

Name you want to be called: _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Mailing Address:_____
Street

_____
State Zip

Home Phone: _____

Work Phone: _____

Occupation: _____

Person responsible for account:_____

Method of payment: Insurance ☐ Credit Card ☐ Cash ☐

Whom should we notify in case of emergency?

_____
Name Phone #

Name of nearest relative, not living with you:

Name:_____

Address:_____Phone: _____

Whom may we thank for referring you to our office?

_____

Social Security #: _____

Driver's License #: _____

Primary Dental Insurance Coverage

Employee Name: _____

Employee Date of Birth:_____

Employer: _____

Insurance Co.: _____

Insurance Co. Address: _____

_____

Phone #:_____

Employee Social Security Number: _____

Policy #: _____

Secondary Dental Insurance Coverage

Employee Name: _____

Employee Date of Birth:_____

Employer: _____

Insurance Co.: _____

Insurance Co. Address: _____

_____

Phone #:_____

Group #: _____

Employee Social Security Number: _____

RELEASE:

I authorize the doctor to perform diagnostic procedures and treatments as may be necessary for proper dental care.
I authorize 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.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I understand that I am ultimately responsible for all costs of dental treatment, regardless of Dental Insurance.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

Patient's or Guardian's Signature: _____ Date:_____

PATIENT HEALTH RECORD

Name_____

Medical Doctor's Name_____Dr. Phone #_____

Are you under a doctor's care now?_____Why?_____

Have you been hospitalized during the past 2 years? Why?_____

Please circle if you have had any of the following:

A.
1. Heart Murmur
2. Rheumatic Fever
3. Artificial Heart Valve
4. Artificial Joint
5. Heart Pacemaker
6. Congenital Heart Defect
7. Mitral Valve Prolapse
8. Eye Surgery

B.
1. Organ Transplant
2. Cancer
3. Chemotherapy/Radiation
4. Glaucoma
5. Stomach Problems
6. Ulcers/Colitis
7. Diabetes
8. Liver Disease
9. Kidney Trouble
10. Drug Dependency
11. Hives or Skin Rash
12. Osteoporosis

C.
1. Heart Trouble
2. High Blood Pressure
3. Low Blood Pressure
4. Chest Pain/Angina
5. Shortness of Breath
6. Stroke
7. History of Fainting
8. Congestive Heart Failure

D.
1. Allergies

Problems with any of the following:

2. Novocaine
3. Sulfides
4. Nitrous Oxide
5. Aspirin
6. Ibuprofen
7. Codeine
8. Penicillin
9. Erythromycin
10. Latex
11. Other

E.
1. Tuberculosis (TB)
2. Venereal Disease
3. Hepatitis___
4. Yellow Jaundice
5. Herpes
6. Blood Transfusion
7. HIV (tested positive or think you may have)

F.
1. Thyroid Disease
2. Asthma
3. Breathing Problems
4. Epilepsy or Seizures
5. Anemia
6. Arthritis
7. Bleeding Problems
8. Bruise Easily
9. Hormone Imbalances
10. Adrenal Gland Disease
11. Psychological Disorders

Are you taking any medication or drugs? Please list:_____

1._____3._____5._____

2._____4._____6._____

Do you have any other health problems, allergies, or conditions you think we should know about?

_____

Do you wish to talk to the doctor privately about any problems?_____

_____

Patient Signature (Parent or Guardian) Date Reviewed by BP

FOR WOMEN ONLY:

Is there any chance you might be pregnant? Yes☐ No☐ If yes, please put due date: _____

Are you nursing?_____ Are you taking birth control pills or using Norplant?_____

MEDICAL UPDATE:

I have read my medical history and confirm that it accurately states past and present conditions.

DATE	CHANGES	PATIENT'S SIGNATURE	REV BY	BP
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DENTAL HEALTH INFORMATION

Why did you come to the Dentist today? ____ Relief of pain ____ Checkup ____ Cosmetic (to change my smile)

____ Other _____

When was your last thorough dental exam? _____

Do you want to keep your teeth? ....._____ Yes _____ No _____ Not sure

When was the last time you had your teeth cleaned professionally?_____

Did your previous Dentist screen you for periodontal disease and oral cancer?_____ Yes _____ No _____ Not sure

Have you taken antibiotics for any reason within the last three months? _____ Yes _____ No

Have you ever had? (please check) ✓

_____ Swelling in your mouth

_____ Orthodontics (braces)

_____ An injury to your face or jaws

_____ Gum treatment or surgery

_____ Clicking or popping noises when moving your jaws

_____ Bleeding gums

_____ Painful or tired jaws

_____ Drifting teeth

_____ Frequent headaches

_____ Loose teeth

_____ Frequent earaches

Do you have any of the following problems? (please check) ✓

_____ Bad breath or a bad taste in your mouth

_____ Missing teeth

_____ Food packing between your teeth

_____ Trouble chewing on either side of your mouth

_____ High or rough fillings

_____ Dry mouth while chewing or swallowing

Are your teeth sensitive to: _____ sweets _____ toothbrushing _____ cold _____ hot _____ biting

Are you satisfied with your past dentistry? ____ Yes ____ No

In the past have you had the opportunity to choose the dental filling materials used, such as gold, porcelain or silver?

____ Yes ____ No

Do you feel nervous about having dental treatment? ____ Yes ____ No ____ Somewhat

Are you interested is using: ____ Nitrous Oxide ____ Stereo Headphones ____ Sedative premedication

Do you like your smile? ____ Yes ____ No

Notes _____

_____

_____

GENERAL DENTISTRY INFORMED CONSENT

DENTIST: Thomas Dugan dmd/Scott Howe dmd **PATIENT:**……

1.- WORK TO BE DONE

I understand that I am having the following procedures performed: Fillings ( ), Crowns( ),Bridges( ), Extractions( ), Root Canals( ), Periodontal Treatment( ), Dentures( ), Orthodontic Treatment ( ), Others( ) (Initials : …….)

2. DRUGS AND MEDICATION

I understand that antibiotics, anesthetics, analgesics and other medications can produce allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. Some medications that I might be currently taking could produce undesired effects or interfere with the normal process of healing (for example aspirin could produce excessive bleeding during extractions, etc). I understand that filling the health questionnaire out to the best of my knowledge is important in order to be prepared for any recommended procedure. (Initials : …….)

3. CHANGES IN TREATMENT PLAN

I understand that during the treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. For example, I may need root canal therapy following routine restorative procedures or extraction of a tooth previously treated with root canal treatment. The dentist will explain all changes. (Initials : …….)

4 REMOVAL OF TEETH

Alternatives, benefits and consequences to the removal of teeth (root canal therapy, crowns, and periodontal surgery) have been explained to me and I authorize the dentist to remove the following teeth ……If any others extractions are necessary the dentist will explain it according to the paragraph #3 before the procedure. I understand that removing teeth may not always remove all the infection present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility (Initials : ……)

5. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may cause tooth movement or recurrent decay. This may necessitate a remake of the crown, bridge, or cap. I understand that a root canal may be needed, even though the tooth may not have hurt prior to the crown or bridge having been done. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that the remaking of existing crowns or bridges imply certain risks like pulp involvement, fracture of root, etc; that could lead to further unexpected procedures.(Initials : …….)

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling may extend beyond the tooth root which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it. (Initials: …….)

7 PERIODONTAL TREATMENT

I understand that I have a condition, causing gum and bone inflammation that can lead to the loss of teeth. Alternative treatment plans have been explained to me, including Deep cleaning, gum surgery, locally administered antibiotics, bone replacements and/or extractions. I also understand that the success of the periodontal treatment depends not only on the procedure performed but also on the daily personal care.(Brushing and flossing) (Initials: …….)

8. FILLINGS

I understand that care must be exercised in chewing on new fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the fillings being done. I understand that sometimes it is not possible to match the color of natural teeth exactly with white fillings (Composites) especially when replacing existing metal fillings. (Initials : …….)

9. DENTURES

Sore spots, altered speech, and difficulty in eating are common problems with new dentures. The ability to adapt to removable dentures varies widely. In some cases, a patient cannot or will not be able to use the device through no fault of fabrication. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. I understand that (Initials : …….)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot completely guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient (Parent or Guardian) …… **Date** ……

Signature of Doctor:..... **Witness**……

Effective date of notice: January 01, 2013

NOTICE OF PRIVACY PRACTICES

Riverfront Dental, LLC
Thomas Dugan, D.M.D.
Scott Howe, D.M.D.
1505 Water St NE, Salem, OR 97301
503-370-7651

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

We will ask for special written permission in the following situations: Transferring your dental records to a new office.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Thomas Dugan and Dr. Scott Howe's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____