REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

SS#/Patient ID #_____

Patient Name_____

Address_____

City_____State_____Zip_____

How Long?_____ Rent ☐ Own☐

E-mail_____

Sex ☐M ☐F Age_____ Birth Date_____

Driver's License #_____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered For____Years

Occupation_____

Patient Employer/School_____

How long at this employer/school?_____

Employer/School Address_____

Employer/School Phone_____

Spouse's Name_____

Spouse's Birth Date_____

Spouse's SS#_____

Spouse's Employer_____

How did you hear about our office? _____

_____

Who is financially responsible for this account?_____

_____

2 DENTAL INSURANCE

Relationship to Patient_____

Insurance Co._____

_____

Group#_____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Insurance Assignment

I certify that I, and/or my dependents(s), have insurance coverage

with_____and assign directly to
Name of insurance company(ies)

Dr._____

all insurance benefits, if any, otherwise payable to me for services rendered.

Financial and Personal Health Information

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information for treatment, payment and health care operations. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____)_____Work (_____)_____Ext _____ Cell Phone (_____)_____

Spouse's Work (_____)_____Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

4 MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

Pharmacy Name_____

Phone (___)_____

ALLERGIES

☐Aspirin ☐Local Anesthetic

☐Barbiturates (Sleeping pills) ☐Penicillin

☐Codeine ☐Sulfa

☐Iodine ☐Other_____

☐Latex _____

5 DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____
City/State_____
Date of last dental visit_____
Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐Yes	☐No
Bleeding Gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry Mouth	☐Yes	☐No
Fingernail Biting	☐Yes	☐No
Food collection between the teeth	☐Yes	☐No
Foreign Objects	☐Yes	☐No
Grinding Teeth	☐Yes	☐No
Gums swollen or tender	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Mouth Breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic Treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Periodontal Treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sore or growths in your mouth	☐Yes	☐No

How often do you floss?_____
How often do you brush?_____

6 HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Epilepsy	☐Yes	☐No	Respiratory Disease	☐Yes	☐No
Anemia	☐Yes	☐No	Fainting or Dizziness	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Glaucoma	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No	Headaches	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Artificial Joints	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Problems	☐Yes	☐No	Skin Rash	☐Yes	☐No
Back Problems	☐Yes	☐No	Hepatitis Type_____	☐Yes	☐No	Special Diet	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No	Herpes	☐Yes	☐No	Stroke	☐Yes	☐No
Blood Disease	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Swollen Feet or Ankles	☐Yes	☐No
Cancer	☐Yes	☐No	Jaundice	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Jaw Pain	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Circulatory Problems	☐Yes	☐No	Liver Disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Tumor or growth on head or neck	☐Yes	☐No
Cortisone Treatments	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Ulcer	☐Yes	☐No
Cough, Persistent/Bloody	☐Yes	☐No	Nervous Problems	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Pacemaker	☐Yes	☐No	Weight Loss (unexplained)	☐Yes	☐No
Emphysema	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Women: Are you pregnant?	☐Yes	☐No
			Radiation Treatment	☐Yes	☐No			

ACCOUNT INFO
ACCOUNT NAME _____

ADDRESS _____

_____

TRUTH IN LENDING
EXPLANATION OF LATE CHARGES AND FINANCE CHARGES

LATE CHARGE: If your minimum payment is not received by the due date, you may be assessed a late payment charge. The amount of the late payment charge to be assessed is the maximum amount authorized under the laws of the state of your domicile. In AZ, CA, ID, IL, IN, KS, NV, OR, TN, UT, WA and WY the late charge will be $5.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $20.00 ($17.50 in IN and $25.00 in KS). In CO, KY, MI, MO, OH, OK, PA, TX and WI the late charge will be $1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00. In MN the late charge will be 50¢ or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00. In GA the late charge will be 5% of the past due minimum payment with a maximum of $10.00. In NE no late charges are assessed. In IN, if the minimum payment is received within 10 days after the due date the late charge will be waived.

FINANCE CHARGE: A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of the statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown below. The finance charge is a monthly periodic rate of 1.25% (.67% in KY, .58% in MI, .83% in MO, 1% in WA and 1.5% in WV). The finance charge is an annual periodic rate of 15% (8% in KY, 7% in MI, 10% in MO, 12% in WA and 18% in WV). There is a $1.00 minimum finance charge (50¢ minimum in IN and MN). In NE no finance charges are assessed.

NON SUFFICIENT FUNDS (NSF) FEE: FPC will charge $25 per payment ($10 in KS) that is returned due to insufficient funds in your account. The NSF fee will be added to your account balance.

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights.

In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

_____
Dental Entity Name

_____ _____
Signature of Patient Date

General Dentistry Informed Consent

Dentist: _____ Patient: _____

1. DRUGS AND MEDICATION: I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock.

(Initials_____)

2. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example: root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.

(Initials_____)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly 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 hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. 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's fees, or court costs, that may be incurred to satisfy this obligation.

Signature of Patient: _____ Date: _____

Signature of Patient Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____