
818 W. 6th St., Ste. 3
The Dalles, OR 97058
541.296.9134

**Patient Information:**

Name of Patient:_____
Last First MI Preferred

Date of Birth: _____ Gender: _____

Marital/Domestic Status: _____ Referred By: _____

Mailing Address: _____

City: _____ State: _____ Zip_____ EMAIL: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Physical Address (if different than above): _____

City: _____ State: _____ Zip:_____

Employer: _____ Phone: _____

Physicians Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

**Financially Responsible Party**

Name: _____ Date of Birth _____

Home Phone: _____ Cell Phone: _____

Employer_____ Work phone: _____ Ext: _____

Mailing Address: _____

City: _____ State: _____ Zip_____ EMAIL: _____

_____
Patient/Responsible Party Signature Date

RIVER DENTAL
CENTER

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**Patient Health History**

Patient Name: _____

Date of Birth: _____

Date of Last Dental Exam: _____

What brings you to our office today? _____

**Dental History**

Yes / No Please answer the questions below by checking 'yes' or 'no'. If unsure, please leave blank.

____ _____ Do you feel pain in your teeth? If so, where? _____
____ _____ Do your gums bleed while brushing or flossing?
____ _____ Are your teeth sensitive to (circle all that apply) Hot Cold Sweets Biting Pressure
____ _____ Do you grind or clench your teeth?
____ _____ Do you have sores or lumps in your mouth that you are concerned about?
____ _____ Do you have broken teeth or broken fillings? (Circle) Upper Right / Left Lower Right / Left
____ _____ Have you had prolonged bleeding following an extraction?
____ _____ Does food get stuck between your teeth?
____ _____ Do you use dental floss? How often do you floss? _____
____ _____ Have you ever been treated for periodontal disease?
____ _____ Do you have pain in your jaw joint or frequent headaches?

**Medical History**

Physician's Name: _____ Clinic or Office Name: _____
Office Address: _____ Phone Number: _____
Pharmacy Name: _____

**Have you at any point been diagnosed (with or without a positive test) with Covid-19? _____If yes, when was the diagnosis or positive test? _____**

Yes / No Please answer the questions below by checking 'yes' or 'no'. If unsure, please leave blank.

____ _____ Have you been hospitalized in the last 5 years? Reason _____
____ _____ Have you been asked to take antibiotics before a dental procedure?
____ _____ Do you have any allergies to medications? (Circle) Penicillin, Vicodin, Codeine, Tetracycline,

E-Mycin, Aspirin, Other: _____
____ _____ Are you currently under the care of a physician?
____ _____ Do you or have you ever used tobacco products? If so, which _____
____ _____ Are you currently taking any medication: Prescription, Over the Counter, Herbals, Supplements, Recreational? Please list drug, dose and frequency: _____

(over)

**General Conditions:**

| Yes | / | No | |
|---|---|---|---|
| ____ | | _____ | Arthritis/Rheumatism |
| ____ | | _____ | Artificial Joint: location _____ year of surgery: _____ |
| ____ | | _____ | Cancer/Tumor: location_____ year of diagnosis: _____ |
| ____ | | _____ | Chemotherapy/Radiation Treatment: Area _____ |
| ____ | | _____ | Diabetes |
| ____ | | _____ | Fainting Spells/Seizures |
| ____ | | _____ | Glaucoma |
| ____ | | _____ | Hepatitis A / B / C |
| ____ | | _____ | HIV or AIDS |
| ____ | | _____ | Kidney Disease |
| ____ | | _____ | Liver Disease |
| ____ | | _____ | Neurological disorder |
| ____ | | _____ | Psychological disorder |
| ____ | | _____ | Respiratory problems |
| ____ | | _____ | Asthma |
| ____ | | _____ | Allergies/hives |
| ____ | | _____ | Sinus Problems |
| ____ | | _____ | Tuberculosis |
| ____ | | _____ | Ulcers |
| ____ | | _____ | Diet/Special Restrictions |
| ____ | | _____ | Latex Sensitivity |
| ____ | | _____ | Abnormal Bleeding |
| ____ | | _____ | Anemia |
| ____ | | _____ | Blood Transfusion |
| ____ | | _____ | Leukemia |
| ____ | | _____ | Bruise Easily |
| ____ | | _____ | Heart Murmur |
| ____ | | _____ | Rheumatic fever |
| ____ | | _____ | Mitral Valve Prolapse |
| ____ | | _____ | Angina/Chest Pain |
| ____ | | _____ | Artificial valve/shunt/stent (Circle any that apply) |
| ____ | | _____ | Heart Attack |
| ____ | | _____ | Heart Disease |
| ____ | | _____ | High / Low Blood Pressure (Circle one) |
| ____ | | _____ | Pacemaker |

For Women: Do you suspect you are PREGNANT? Yes / No; Number of weeks: _____
Birth Control pills? Yes / No Breast Feeding Yes / No

Do you have any health condition not listed above? Yes / No If so please list condition(s):_____

Emergency Contact: _____ Phone: _____

To the best of my knowledge all of the preceding answers are correct. If I ever have a change in my health or medication, I will inform the dentist at the next appointment.

Patient/Responsible Party Signature: _____Date: _____

_____Office use only_____

*Dentist Signature:* _____ *Date:* _____

*ASA classification:*_____

RIVER DENTAL
CENTER

**Primary Insurance:**

Subscriber Name: _____ Date of Birth: _____
Last First MI

Subscriber Social Security Number: _____ Subscriber Employer: _____

Relationship to the Subscriber: _____

Insurance Provider: _____ Insurance Phone: _____

Insurance Address: _____

Member ID: _____ Group number: _____ Effective Date: _____

Deductible Amount: _____ Deductible Met: _____

Yearly Maximum Coverage: _____ Yearly Maximum Remaining: _____

**Secondary Insurance:**

Subscriber Name: _____ Date of Birth: _____
Last First MI

Subscriber Social Security Number: _____ Subscriber Employer: _____

Relationship to the Subscriber: _____

Insurance Provider: _____ Insurance Phone: _____

Insurance Address: _____

Member ID: _____ Group number: _____ Effective Date: _____

**Financial Responsibility, Release of Information, and Assignment of Insurance Benefits**
I request all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to River Dental Center, LLC. **I understand I am financially responsible for all charges for services performed by River Dental Center, LLC. If Insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the difference.** I authorize River Dental Center, LLC., to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children. **Failure to provide complete information may result in receiving a bill for services.**

Patient Name Date

Signature of Patient or Responsible Party Relationship to patient


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# Patient Financial and Treatment Policy

**Appointments:**
All patients are seen on an appointed basis. This policy ensures each patient is allowed adequate time for us to provide the best care possible. If you need to cancel or reschedule an appointment, we require 48 hours notice. Appointments cancelled with less than 2 business days notice may result in a missed appointment fee of $70 for an appointment of 1 hour or less and $160 for a scheduled appointment of longer than 1 hour.

**Fees and Payment:**
The fees we quote for procedures are estimates only. It is possible that modifications to your Treatment Plan and estimated fees may be necessary at some point during the course of treatment. Should this occur, we will notify you of any changes.

Your estimated co-payments, co-insurance, and any amount not covered by your insurance are due at the time of service. If you do not have insurance, payment is due in full at the time of service. We accept cash, check, money orders, Discover, Mastercard, Visa and CareCredit.

If any portion of an insurance claim is not paid by your insurance carrier, the amount not covered is due upon request. A finance charge of 1.5% per month (an annual percentage rate of 18%) will be assessed on accounts over 60 days old. Delinquent accounts will be referred to collections after 120 days.

**Insurance:**
Our relationship is with you, our patient, and not your insurance company. As a courtesy, we will submit a claim to the insurance company for which you have provided billing information. If you have any changes to your insurance information, please provide the updated information to our office personnel as much in advance of your appointment as possible.

Insurance policies are very complex and individual. We make every effort to process your dental claims as quickly as possible. However, it is impossible for us to know the details of every dental plan. Your plan administrator or HR person at your place of employment is the best source for information regarding your individual coverage. Thank you for your understanding.

**Financial Agreement:**
I understand that I am responsible for charges and procedures not covered by my insurance which may include deductibles. I agree to pay for the services rendered according to River Dental Center, LLC's fees and terms. If my insurance company denies payment, I agree to be personally and fully responsible for payment in full.

_____

Patient Name Date

_____

Signature of Patient or Responsible Party Relationship to Patient


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**Patient Privacy Form**

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of personal health information in order to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may work with companies which have indirect treatment relationships with you (such as laboratories that only interact with providers), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Heath Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI disclosure. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our Privacy Notice, to request restrictions and to revoke consent in writing after you have reviewed our Privacy Notice.

_____

Printed Name of Patient Date

_____

Signature of Patient or Responsible Party Relationship to Patient

**Confidentiality Issues:**

Do we have your permission to leave a message on your Voicemail or home Answering Machine relating to your dental care in our office? (Circle One) Yes No

To whom may we speak with regarding your dental Care? Family Member: _____
Friend: _____
Caregiver: _____
Other: _____

What information may we disclose (circle all that apply):

Appointment Confirmation Treatment Plan Financial Information Other (please list): _____


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**Patient Authorization to Release and Exchange Information**

Date: _____

Patient Name: _____ Patient phone number: _____

If Under 18, Name of Legal Guardian: _____

(a) I authorize the dental care professionals of River Dental Center, LLC to release and discuss patient information regarding the above patient's treatment, conditions, or related topics. If the above listed patient is under 18, I certify that I have authorization to sign on this person's behalf. I understand the patient information that is released will be current as of the time this Authorization is signed and if additional information is needed at a later date, I may be asked to sign an additional Authorization Release Form.

(b) I release River Dental Center, LLC and its staff from any and all state or federal laws relating to patient privacy.

(c) I specifically authorize the staff from River Dental Center, LLC to share (or obtain) my dental information, imaging and records (or that of a dependent) with/from:
_____

(d) I give River Dental Center, LLC the right to exchange and/or release my dental records in whole or in part, without limitations to entities upon my authorized request.

(e) I understand I may withdraw or revoke my authorization at any time and such revocation must be given to River Dental Center, LLC in writing. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, I understand any disclosure or publication made prior to a revocation may remain in River Dental Center, LLC's domain. I further understand such withdrawal of authorization will not affect my treatment.

Signature of Patient/Legal Guardian: _____