Camas Center Dental Clinic

FOR OFFICE USE ONLY
Chart #: _____

PATIENT REGISTRATION

Patient Name: _____ Date: ____/____/____
Last First MI Preferred Name

Marital Status: (Circle one) *Single / Married / Widowed / Divorced / Separated / Child / Other*

Gender: M / F Birth Date: ____/____/_____ Social Security#_____

Mail Address _____ Apt#_____ City_____ State _____

Zip Code _____ County _____

Race: (Circle One) Native American / Alaskan Native / Native Hawaiian / Pacific Islander / Caucasian / Hispanic / Asian / African American / Chinese / Filipino / Japanese Enrolled? Y / N Enrollment # _____

Tribe: _____ Eligible for Contract Health Services? Y / N

Phone (Primary) _____ *OK to text? Y / N* (Secondary) _____ *OK to text? Y / N*

Ext #_____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐ M ☐ T ☐ W ☐ T

Email_____ OK to email?: Y / N Confirmations for appointments: Y / N Newletters: Y / N

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

(Circle one) Web Page / Yellow Pages / Newspaper / Radio / Work / Brochure / Flyer / Other _____
Please specify

Name of person or office referring you to our practice: _____

Previous Dentist _____

Address _____ **City** _____ **State** _____ **Zip** _____

Telephone _____ **E mail** _____ **Fax** _____

Reason for leaving?_____

What did you like about your previous dental office experiences?

_____

What did you dislike? _____

SPOUSE or RESPONSIBLE PARTY INFORMATION

The following is for: ☐ Patient's Spouse ☐ Person responsible for payment

Name: _____ Gender: M / F

Marital Status: (Circle one) *Single / Married / Widowed / Divorced / Separated / Child / Other*

Social Security #: _____ Birth Date: ____ / ____ /_____

Address: _____ City_____ State _____ Zip _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Employment Information

The following is for: ☐ Patient ☐ Person responsible for payment

Employer Name: _____Occupation: _____

Address: _____City _____ State _____ Zip _____

Phone: _____

INSURANCE INFORMATION

PRIMARY:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Address: _____ City _____ State _____ Zip _____

Insured's Employer Name: _____

Address: _____ City _____ State _____ Zip _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

SECONDARY:

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Address:_____ City _____ State ____ Zip _____

Insured's Employer Name: _____

Address: _____ City _____ State ____ Zip _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name _____

Address: _____ City _____ State ____ Zip_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____ Date: _____ / _____ / _____ Relationship to Patient: _____
Signature of Patient, Parent or Guardian

STAFF USE ONLY:

Date:_____

Received by: _____

Date Entered:_____

FULL LEGAL NAME:_____Date of birth:_____

1. PATIENT AUTHORIZATION FOR COMMUNICATION OF INFORMATION

Camas Center Clinic is committed to privacy and confidentiality. Your medical information will be kept confidential to the degree required under existing law and regulations. However, from time to time we may need to contact you at home or work. If we need to contact you, may we have your permission to leave a message in regard to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone?

I authorize/request Camas Center Clinic to:

{ } YES { } NO Leave a message on my answering machine/cell phone?

{ } YES { } NO Leave a general (non-detailed) message at my place of employment?

{ } YES { } NO Leave a message with individuals in my household?

If Yes, Please indicate with whom we may leave a message:

Name:_____Relationship:_____

Name:_____Relationship:_____

2. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

The HIPAA Privacy Rule was developed to protect the confidentiality of Individually Identifiable health information and other personal information. The **Health Insurance Portability and Accountability Act** (HIPAA) is a federal law. The notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. The privacy of your medical information is important to us.

We will use your Protected Health Information in the following ways:

- For treatment purposes at the Camas Center Clinic and to/from referring medical and dental Providers
- For Payment processes related to insurance claims and collection
- For operations such as treatment alternatives, appointment reminders, and to conduct our day to day business and service operations

Please read a complete copy of our Notice of Privacy Practices:
If you have any questions, concerns or complaints please contact:
The Camas Center Clinic HIPAA Privacy Officer (509) 447-7111

3. CANCELLATION/NO-SHOW POLICY

Due to the limited time slots available for clinic appointments, it is important the all patients attend their SCHEDULED appointments. If you are unable to attend, it is expected that you call and inform the Camas Center Clinic at least **1 day prior** to your appointment. **If you do not cancel at least 24 hours prior to your scheduled appointment, arrive more than 10 minutes late, or do not show for your appointment, this is considered a "No-Show"** As a policy, if you have more than 2 No-Shows, we reserve the right to discontinue services until a consult between you and your provider and/or business manager can be scheduled. Thank you for your understanding in this matter.

I HAVE READ AND UNDERSTOOD THE ABOVE POLICIES

Signature:_____ Date:_____

HEALTH INFORMATION

PATIENT NAME: _____ **DATE:** ____ /____ /_____

Date of Last Dental Visit _____/ _____ /_____
What concerns brought you to the Dentist today? _____
_____

Do you require antibiotics before dental treatments _____Yes _____No
Are you currently in pain? _____Yes _____No
Have you ever had a serious/difficult problem
associated with any previous dental work? _____Yes _____No
Do you have or have you ever experienced
pain/discomfort in your jaw joint?(TMJ/TMD)? _____Yes _____No
Your current dental health is: _____Good _____Fair _____ Poor
Do you like your smile? _____Yes _____No
Do your gums bleed? _____Yes _____No
How many times a week do you FLOSS? _____
How many times a day do you BRUSH? _____
What type of bristles do you use on your toothbrush: _____Soft _____ Medium _____ Hard
How often do you replace your toothbrush? _____
Are your teeth sensitive to heat, cold or anything else? _____
Have you lost any teeth? _____Yes _____No If yes, explain: _____
_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies
  _____
  _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
  Pacemaker
- ☐ **Pregnancy**
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
  - o Tetracycline
  - o Other
  - o Erythromycin
- o Metals/Plastics
- o Dental Anesthetics
- o Latex
- o Aspirin
- o Any other drug/ material allergies?
  Please List:
  _____
  _____
  _____
  _____

Do you use tobacco?? Yes____ No_____ if Yes –Smoke_____ or Chew_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

_____
Please list any Medications you are currently taking_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Sign: _____ Date: _____