ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign The Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

_____
(Or Signature of Legal Representative) (Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

P.O. Box 1487 * Florence, OR 97439

CHAD E. CLEMENT, D.D.S., P.C.

Authorization to Release Medical Information

Patient Name:_____

I authorize the following to have access to my medical/dental records and receive phone messages.

[ ] Name_____ Relationship _____

[ ] Name_____ Relationship _____

[ ] Name_____ Relationship _____

[ ] Name_____ Relationship _____

Authorized phone number to leave messages:_____[ ] Home [ ] Cell [ ] Work

*******Who may we contact in case of an emergency?*******

Name:_____ Phone _____

Name:_____ Phone _____

_____ _____

Patient/Guardian Signature ***Date***

P.O. Box 1487 * Florence, OR 97439

CHAD E. CLEMENT, D.D.S., P.C.

HEALTH HISTORY FORM

Date _____

Name _____

Home Phone (___)_____ Cell (___)_____ Work (___)_____

Street Address _____ City _____ State _____ Zip Code _____

Mailing Address if different than above:

Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Sex ☐ M ☐ F Occupation _____ Ref'd By _____

Preferred Pharmacy: _____ SSN:_____ Driver's License #_____

Emergency Contact Name: _____Phone Number: _____ Relationship _____

If you are completing this form for another person, what is your relationship to this person? _____

DENTAL INFORMATION **Signature of Responsible Party:** _____

YES	NO	UNKNOWN	
☐	☐	☐	Do your gums bleed when you brush?
☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?
☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	☐	Do you wear removable/fixed dental appliances?
☐	☐	☐	Have you been told you have periodontal (gum) disease?
☐	☐	☐	Are you aware of loose teeth or broken fillings?
☐	☐	☐	Are your gums swollen or tender?
☐	☐	☐	Are you a mouth breather?
☐	☐	☐	Have you had any problems associated with any previous dental treatment or past dental experiences? If so explain: _____

YES	NO	UNKNOWN	
☐	☐	☐	Do you frequently get blisters on lips or mouth?
☐	☐	☐	Do you have a family history of Periodontal Disease?
☐	☐	☐	Do you ever get a burning sensation on tongue?
☐	☐	☐	Do you chew on one side of mouth?
☐	☐	☐	Do you get clicking or popping of your jaw?
☐	☐	☐	Do you bite your nails or foreign objects?
☐	☐	☐	Do you get jaw pain or tiredness?
☐	☐	☐	Does food collect between your teeth?
☐	☐	☐	Do you have pain when brushing?
☐	☐	☐	Do you or have you been told you grind your teeth?

How would you describe your current dental problem?

_____

Oral habits (Circle all that apply)

Tongue/lip piercing Ice chewing Musical instrument with mouthpiece Using mouth as a tool

What fluoride products do you use/consume? (Circle all that apply)

Toothpaste Water Rinses Other _____

How do you feel about the appearance of your teeth? _____

Do you have any problems with bad breath? _____

How often do you floss? _____/day

How often do you brush? _____/day

How often do you have dental check ups? _____

CHAD E. CLEMENT, D.D.S., P.C.

MEDICAL INFORMATION

Physician(s) _____
Name Phone

_____
Address City/State/Zip

YES	NO	UNKNOWN	
☐	☐	☐	Are you in good health?
☐	☐	☐	Have there been any changes in your health within the past year?
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated? _____Date of last exam_____
☐	☐	☐	Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem? _____
☐	☐	☐	Do you consume snacks/beverages containing sugar between meals? How many times per day? _____

What is your history of tobacco use?

	Cigarette, Cigar or Pipe Use				*Smokeless Tobacco Use*		
	Never smoked cigarettes	Age began	Year Quit		Never used smokeless tobacco	Age began	Year Quit
	Former smoker				Former user		
	<10 per day				Occasional user		
	≥10 per day				Daily user		

Are you taking any medications (Prescription or Over-the-Counter)?

Name of Drug	Purpose	Date

Have you EVER taken any Bisphosphonates? ✹ YES ✹ NO

Are you allergic to or have you had a reaction to?

YES	NO	UNKNOWN	
☐	☐	☐	Local Anesthetics
☐	☐	☐	Penicillin or other antibitoics
☐	☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	☐	Sulfa Drugs
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Latex
☐	☐	☐	Iodine
☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Metal

Please list any drugs or medicines that you cannot or prefer to not take because of allergies or side-effects especially antibiotics for infections, analgesics for pain, and anesthetics. _____
What is your preferred drug for mild and/or severe pain? _____
What is your preferred antibiotic for an infection? _____

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Please (x) a response to indicate if you have or have had any of the following diseases or problems

YES	NO	UNKNOWN	
☐	☐	☐	Abnormal Bleeding Controlled? (circle one): Good Fair Poor
☐	☐	☐	AIDS or HIV
☐	☐	☐	Anemia
☐	☐	☐	Herpes
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatiod Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood Transfusion If yes, date _____
☐	☐	☐	Cancer/Chemotherapy/Radiation
☐	☐	☐	Cariodovascular diseases?
			_____ Angina Pectoris
			_____ Heart Murmur
			_____ Bypass Surgery
			_____ Mitral Valve Prolapse
			_____ Pacemaker
			_____ Rheumatic Fever
			_____ Artificial Valves
			_____ Heart Attack Date _____
☐	☐	☐	Chest Pain/Shortness of breath upon exertion
☐	☐	☐	Chronic Pain
☐	☐	☐	G.E. Reflux, persistent heartburn, or Gastrointestinal Disease
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, Jaundice, or Liver Disease
☐	☐	☐	High/ Low Blood Pressure
☐	☐	☐	Recurrent Infection If yes, what type of infection _____
☐	☐	☐	Diabetes
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	Dry Mouth

YES	NO	UNKNOWN	
☐	☐	☐	Joint Replacement
☐	☐	☐	Eating disorder If yes, please specify _____
☐	☐	☐	Disease, drug or Radiation-induced immunosuppression
☐	☐	☐	Mental Health disorder
☐	☐	☐	Night sweats/ Menopausal
☐	☐	☐	Neurological disorders
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands
☐	☐	☐	Respiratory problems If yes, please specify
			_____ Emphysema
			_____ Bronchitis, etc.
☐	☐	☐	Severe headaches/migraines
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus Trouble
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke If yes, date _____
☐	☐	☐	Systemic Lupus Erythematosus
☐	☐	☐	Tuberculosis
☐	☐	☐	Thyroid problems
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination/thirst
☐	☐	☐	Do you have any disease not listed above that you think we should know about? Please explain: _____
☐	☐	☐	Have you ever been told you needed to Pre-medicate for dental treatment?
☐	☐	☐	Are you pregnant?
☐	☐	☐	Are you planning to be pregnant?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any action they take because of errors or ommission that I may have made in the completion of this form.

_____

SIGNATURE OF PATIENT/LEGAL GUARDIAN

_____

DATE

CHAD E. CLEMENT, D.D.S., P.C.

INSURANCE INFORMATION

Policy Holder/Subscriber name _____ Relationship to Patient _____

Subscriber _____ Subscriber SSN# _____

Name of Employer _____ Union or Local #_____ Insurance Co. Phone _____

Address of Ins Co. _____ City _____ State _____ Zip _____

Insurance Company _____ Group #_____ Policy/ID#_____

Max annual benefit_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❒ YES ❒ NO

IF YES, COMPLETE THE FOLLOWING:

Policy Holder/Subscriber name _____ Relationship to Patient _____

Subscriber _____ Subscriber SSN # _____ Date Employed _____

Name of Employer _____ Union or Local #_____ Insurance Co. Phone _____

Address of Ins Co. _____ City _____ State _____ Zip _____

Insurance Company _____ Group #_____ Policy/ID#_____

How much is your deductible?_____ How much have you used?_____

Max annual benefit_____

CHAD E. CLEMENT, D.D.S., P.C.

Dental Services Agreement

Office Policy

I understand that I may be charged up to $50.00 for missed appointments without 24 hours notice. I understand that I am ultimately responsible for payment of services rendered.

Payment Policy

Payment in full is required for all new patients that do not have dental insurance or if the dental insurance cannot be verified. Financial arrangements are only allowed if an unforeseeable situation occurs. All statements are sent one time a month. If after 90 days there is still a balance on the account (regardless of insurance delays) a finance charge may be assessed. A minimum of $5.00 or 18% annual percentage rate, whichever is greater, will be charged to your account. If I do not abide by this agreement and my balance becomes delinquent and no arrangements can be made, I understand my account will be forwarded to a collection agency.

Patient Signature _____ Date _____

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