



New Patient Packet



Date _____

Patient's name _____

Last

First

Middle

Address _____

Street

City

Zip

Nickname _____ Birthdate _____ Social Security # _____

School Currently Attending: _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____

Last

First

Middle

Residence _____

Street

City

Zip

Mailing Address _____

Street

City

Zip

How long at this address? _____ Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____

Street

City

Zip

Phone _____

MEDICAL INSURANCE INFORMATION

Policy Holder's Full Name _____ Policy Holder's Relation to Patient: _____

Insured's Social Security _____ Policy Holder's Date of Birth: _____

Policy Holder's Mailing Address: _____

Insurance Company _____ Group No. _____ Subscriber ID No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Policy Holder's Full Name _____ Policy Holder's Relation to Patient: _____

Insured's Social Security _____ Policy Holder's Date of Birth: _____

Policy Holder's Mailing Address: _____

Insurance Company _____ Group No. _____ Subscriber ID No. _____

Insurance Co. Address _____ Phone No. _____

DENTAL INSURANCE INFORMATION

Policy Holder's Full Name _____ Policy Holder's Relation to Patient: _____

Insured's Social Security _____ Policy Holder's Date of Birth: _____

Policy Holder's Mailing Address: _____

Insurance Company _____ Group No. _____ Subscriber ID No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Policy Holder's Full Name _____ Policy Holder's Relation to Patient: _____

Insured's Social Security _____ Policy Holder's Date of Birth: _____

Policy Holder's Mailing Address: _____

Insurance Company _____ Group No. _____ Subscriber ID No. _____

Insurance Co. Address _____ Phone No. _____

Please complete **BOTH** sides of this form.

HEALTH HISTORY

Patient Name:		Date of Birth:
Primary Care Physician (name & phone number):		
Heart	<input type="checkbox"/> Heart Murmur <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Low/High Blood Pressure <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Other (not listed) Please Explain: _____	
Kidney	<input type="checkbox"/> Bladder <input type="checkbox"/> Urinary Problems <input type="checkbox"/> Other Please Explain: _____	
Liver / GI	<input type="checkbox"/> Reflux (GERD) <input type="checkbox"/> Stomach/Intestine Ulcers <input type="checkbox"/> Gastritis <input type="checkbox"/> Colitis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver Disease <input type="checkbox"/> Other (not listed) Please Explain: _____	
Endocrine	<input type="checkbox"/> Diabetes Type: _____ <input type="checkbox"/> Thyroid Disease (Hyper/Hypo) <input type="checkbox"/> Other (not listed) Please Explain: _____	
Hematologic	<input type="checkbox"/> Anemia <input type="checkbox"/> Hemophilia <input type="checkbox"/> Leukemia <input type="checkbox"/> Sickle Cell Disease / Trait (circle) <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Blood Transfusion (latest date: _____ / Started: _____) <input type="checkbox"/> Other (not listed) Please Explain: _____	
Lung / Respiratory	<input type="checkbox"/> Asthma <input type="checkbox"/> Allergies/Hives <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Hay Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other Please Explain: _____	
Neurological	<input type="checkbox"/> ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Speech Disorder <input type="checkbox"/> Nervous Disorder <input type="checkbox"/> Mental Disorder <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Brain Injury Please Explain: _____	
Hearing / Vision	<input type="checkbox"/> Vision Problems <input type="checkbox"/> Glaucoma <input type="checkbox"/> Earaches <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Other (not listed) Please Explain: _____	
Dermal / Musculoskeletal	<input type="checkbox"/> Latex Allergy <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Fever Blisters/Cold Sores <input type="checkbox"/> Other (not listed) Please Explain: _____	
Does your child have any disease, condition or other health problems not listed above? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medications (names and dosages): Please list ALL taken, including vitamins & supplements	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child have any ALLERGIES to any food or medications? If yes, please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child been hospitalized overnight since birth? If yes, when? Why?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child ever had surgery? If yes, when? Why?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child had radiation or chemotherapy? If yes, when? Why?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child have AIDS or has he/she been tested HIV-positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your child adopted? If yes, does he/she know?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Females: any possibility of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Females: has you/your child begun menstruation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Dental History

What is your primary concern about your child's oral health?

How would you describe:

your child's oral health? Excellent Good Fair Poor
 your oral health? Excellent Good Fair Poor

How often does your child **brush** his/her teeth? _____ times per _____. Does someone help?
 How often does your child **floss** his/her teeth? _____ times per _____. Does someone help?

Yes No
 Yes No

Have there been any injuries to teeth, such as falls, blows, or accidents? When? Please describe:

 Yes No

How frequently does your child have the following?

Candy or other sweets: Rarely 1-2 times/day 3+ times/day Product _____
 Chewing gum: Rarely 1-2 times/day 3+ times/day Type _____
 Snacks between meals: Rarely 1-2 times/day 3+ times/day Usual snack _____
 Soft drinks* Rarely 1-2 times/day 3+ times/day Product _____

(*such as juice, fruit-flavored drinks, sodas, carbonated beverages, sweetened beverages, sports/energy drinks)

Please note other significant dietary habits:

Has your child had any dental treatment completed in the past? When? _____
 If yes, describe: _____

 Yes No

Has your child had any difficult dental experiences in the past?

If yes, describe: _____

 Yes No

Does your child currently have any cavities?

 Yes NoHow do you expect your child will respond to dental treatment? Very well Fairly well Somewhat poorly Very poorly

Is there anything that is concerning you about the appearance of your/your child's teeth?

If yes, describe: _____

 Yes No

Do you feel that you or your child's teeth:

Stick too far forward About right angle Lean too far back or upright
 Too crowded Too spaced Upper jaw too narrow Upper jaw too wide
 Overlap too much when biting (deep bite) No overlap when biting (open bite)

Do you feel that you or your child's jaw is:

Too far forward Too far back Appears to be fine

Are you unhappy with your/your child's smile?

 Yes No

Has your dentist recommended braces in the past?

 Yes No

Has anyone else in your/your child's family had orthodontic treatment?

If yes, who: _____

 Yes No

Has anyone else in your/your child's family had orthognathic (jaw) surgery with braces?

If yes, who: _____

 Yes No

Is there additional information we should know before treating you or your child?

If yes, describe: _____

 Yes No_____
PARENT/GUARDIAN SIGNATURE_____
PRINTED NAME_____
(RELATIONSHIP TO PATIENT)_____
DATE

FINANCIAL POLICIES AND AGREEMENT

Missed Appointment Policy

We work diligently to see all our patients in a timely manner. Missed appointments leave us with holes in our schedule that prevents us from providing timely care for the children in our community. Missed appointments affect everyone. Therefore, we have instituted a “Missed Appointment Policy” which states that **appointments not cancelled within 48 hours minimum advance will be charged a fee of \$50.00.** In the event that you miss 3 scheduled appointments, we will release patient from the office and be happy to forward patient records to your dental office of preference.

Missed Oral Sedation and Operative Appointments

Due to the high demand for sedation appointments, we have implemented a “Missed Surgical / Operative Appointment Policy” to encourage patients to keep their appointments. If you cannot attend your scheduled appointment, you **must call** a minimum of 72 hours in advance. If we do not have a 72-hour advance notice of cancellation, you will be charged a **\$200 non-refundable “Missed Surgical/Operative Appointment Fee”**.

Payment/Insurance Policy

As a courtesy, we file insurance claims for our patients. **All estimated out of pocket portions are due at time of service.** This amount is an estimate of your copayment and we work hard to make this as accurate as possible. **You are responsible for any amount not covered by your insurance.**

Our office accepts cash, check, Visa, MasterCard. We also offer financing through CareCredit and In-House financing.

I understand that I am responsible for the payment for all the fees for dental treatment that are not covered by the patient’s dental or medical insurance. The parent or guardian who accompanies the patient to the appointment will be responsible for estimated portions due at the time of treatment, unless prior arrangements have been made. I agree that should the account be referred for collection, I will be responsible for all collections charges including attorney fees.

PARENT/GUARDIAN SIGNATURE

PRINTED NAME

(RELATIONSHIP TO PATIENT)

DATE

Oregon Pediatric Dental Care LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please Print

<<Print Your Full Name Here>>

Signature

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
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
- _____
- _____

Witness: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Consent to Treatment

Consent to Examine

It is our policy at Oregon Pediatric Dental Care to keep you informed and involved in your child's dental progress. A typical examination consists of oral hygiene instruction, cleaning of the teeth, application of a topical fluoride, x-rays, and examination of the teeth, hard and soft tissue of the mouth, bite, and jaw. Except in an emergent situation or if existing disease is located, no further treatment will be performed during an examination. However, after the examination, we will create a treatment plan that may include fillings, caps, extractions, etc., and will seek your consent prior to performing the identified treatment. Treatment plans may cover multiple visits and once consent is obtained; we will not seek consent again unless the treatment plan changes. By signing below, you give consent for Oregon Pediatric Dental Care, whom manages practices Oregon Family Orthodontics, Newberg Kids Dentist, Springfield Kids' Dentist and Eugene Kids' Dentist to perform an examination as outlined above. You further certify that you have legal authorization to consent to dental and medical treatment for the patient.

_____	_____	_____
Signature	Relationship to patient	Date

Alternative Consent

We recognize that it is not always feasible for the legal parent or guardian to accompany a child to his or her appointment or be available to provide consent for treatment. In an effort for us to ensure that the child is able to continue care, we would like to know if there are others who are authorized to consent to treatment for your child. By signing below, you give authorization for the person(s) listed to consent to recommended medical/dental treatment including, but not limited to, diagnosis, application of topical treatments (fluoride, sealants) x-rays, anesthesia, and invasive dental procedures. This authorization will remain in effect until you notify us in writing of any changes.

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____	_____
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	(RELATIONSHIP TO PATIENT)	DATE