Patient Name: _____ Date: _____

Birth Date: _____ Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone(Home): _____(Cell): _____ Best time to call:_____

Parent/Representative's Name: _____

Medical History

Are you under the care of a physician now?	☐ Yes ☐ No	If yes _____
Have you been hospitalized or had a major operation in the last 5 years?	☐ Yes ☐ No	If yes _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes _____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes _____
Do you take, or have you ever taken Phen-phen or Redux?	☐ Yes ☐ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel, or any Other medication containing bisphosphonates?	☐ Yes ☐ No	If yes _____
Are you on a special diet?	☐ Yes ☐ No	If yes _____
Do you use tobacco?	☐ Yes ☐ No	If yes _____
Do you use controlled substances?	☐ Yes ☐ No	If yes _____

Women: Are you:

☐ Pregnant or trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic/Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following:

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Shingles
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sinus Trouble
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stroke
☐ Breathing Problems	☐ Frequent Headache	☐ Liver Disease	☐ Swelling of the Limbs
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Tonsillitis
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tumors or Growths
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Ulcers
☐ Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Yellow Jaundice
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature:_____ Date: _____

Dental Health Information

Are you having any discomfort currently? Explain: _____

Have you ever had any serious complications associated with previous dental procedures? Explain:

_____

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

How often do you brush? _____ Brush is: ☐ Soft ☐ Medium ☐ Hard

Do you have, or have you ever had any of the following? Please check those that apply:

MOUTH
- ☐ Bleeding, sore gums
- ☐ Unpleasant taste/bad breath
- ☐ Burning tongue/lips
- ☐ Frequent blisters, lips or mouth
- ☐ Swelling/lumps in mouth
- ☐ Braces
- ☐ Biting of cheeks/lips
- ☐ Clicking/popping jaw
- ☐ Difficulty opening or closing jaw

TEETH
- ☐ Loose teeth
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Food impaction
- ☐ Clenching/grinding …
  If so, when? _____
- ☐ Shifting in bite
- ☐ Change in bite

Are you happy with your smile and the appearance of your teeth in general (Color, Shape, Spaces)? _____

If "no", why not? _____

Do you smoke? ☐ Yes ☐ No Do you use any other tobacco product? _____

Frequency of use: _____

Office and Financial Policies

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

APPOINTMENTS

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a 24-hour notice is requested. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

INSURANCE

As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, we do require you to pay your deductible and/or "estimated patient portion" at the time of service. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, please provide us with your dental insurance card and a claim form if needed. Please note that dental insurance plans are different from your medical insurance. When possible, we will submit a dental pre-estimate to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

USUAL AND CUSTOMARY RATES

Please be aware that some of our services may be "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. You are responsible for any balance left unpaid by your insurance company. The adult accompanying a minor is responsible for full payment.

PAYMENT OPTIONS AND ACCOUNT INFORMATION

In order to maintain our fees at a reasonable level, we do not send monthly statements. In the event we receive a returned check for insufficient funds or a closed account, there will be a $35.00 fee charged to your account. Collection fees of 35% of the account balance will be added to any balance turned over for collection purposes.

Thank you for understanding our guidelines. Please let us know if you have any questions or concerns. I have read, understand, and agree to the above office and financial policies.

X _____ _____

Signature of patient or responsible party Date

Consent for Use and Disclosure of Health Information

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

Name: _____

Date: _____

To the patient- Please read the following statements carefully

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Policy, including any revisions, at any time by contacting:

Spencer Tippets DDS, LLC
348 Oak St Central Point, OR 97502
541-664-2210
office@oakstreet.dental

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact information listed above. Please understand that revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Revocation of Consent
I revoke my consent for your use and disclosure of my PHI for treatment, payment activities, and healthcare operations.
I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

Spencer Tippets DDS, LLC

HIPAA RELEASE FORM

This form is for the use and disclosure of Dental Health information, and used when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. For us to stay within the guidelines, please list the name and relationship of anyone that you authorize us to disclose information regarding your Protected Health Information. It is not mandatory for you to list anyone.

NAME RELATIONSHIP

1. _____
2. _____
3. _____

By signing, I consent for the following information to be used or disclosed:

- Treatment
- Scheduling
- Payments/Account Balance

By signing this form, I understand that I am consenting for Spencer Tippets DDS, LLC to disclose my information to the above listed family member, personal representative, friend, or other person to the extent necessary to help with my healthcare or with payment for your healthcare. I understand that I have the right to revoke this consent at any time by contacting the office at Tippets Family Dental. I understand that this consent is not valid unless signed.

_____

Patient Name (Please Print)

_____ _____

Patient or Parent/Guardian Signature Date

This authorization will expire in two years from today's date unless otherwise notified.