Today's Date:_____

Katherine M. Graham, DMD, PC
12672 NW Barnes Rd. Ste #101
Portland, OR 97229

Patient: _____Date of Birth:_____Sex:_____
Last Name First Name Middle

Mailing Address:_____Phone:_____
Street or Box City Zip

Social Security#:_____ E-mail Address:_____Preferred Contact:_____
E-mail/Phone

Emergency Contact:_____Responsible Party:_____
First & Last Name Phone # First & Last Name Phone #

Employer:_____How Long:_____Phone:_____

Primary Dental Insurance:_____Group#:_____ID#_____

Secondary Dental Insurance:_____Group#:_____ID#_____

Insured's Name:_____DOB:_____Relationship:_____

Employer:_____How Long:_____

Referred by:_____Former Dentist:_____
Name Phone/City

How long since your last dental examination or appointment:_____

In the following questions, circle yes or no, whichever applies. Your answers are for our records and will be considered confidential.

Yes No 1. Are you in good health?----------
Yes No 2. Has there been any change in your general health in the past year?----------
3. My last physical examination was on_____
Yes No 4. Are you now under the care of a physician?----------
If so, what is the condition being treated?_____
Yes No 5. The name and address of my physician is_____
_____
_____
Yes No 6. Have you had any serious illness or operation?----------
If so, what was the illness or operation?_____
Yes No 7. Have you been hospitalized or had a serious illness in the last 5 years?----------
If so, what was the problem?_____
8. Do you or have you had any of the following diseases or problems?----------
Yes No a. Damaged heart valves or artificial heart valves, including heart murmur----------
Yes No b. Congenital heart lesions----------
Yes No c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke----------
Yes No 1. Do you have pain in the chest upon exertion?----------
Yes No 2. Are you ever short of breath after mild exercise?----------
Yes No 3. Do your ankles swell?----------
Yes No 4. Do you get short of breath when you lie down, or do you require extra pillows to sleep?----------
Yes No 5. Do you have a cardiac pacemaker?----------
Yes No d. Allergy----------
Yes No e. Sinus trouble----------
Yes No f. Asthma or hay fever----------
Yes No g. Hives or skin rash----------
Yes No h. Fainting spells or seizures----------
Yes No i. Diabetes----------
Yes No 1. Do you have to urinate (pass water) more than six times a day?----------
Yes No 2. Are you thirsty much of the time?----------
Yes No 3. Does your mouth frequently become dry?----------
Yes No j. Hepatitis, jaundice, or liver disease----------
Yes No k. Arthritis----------
Yes No l. Inflammatory rheumatism (painful swollen joints)----------
Yes No m. Stomach ulcers----------
Yes No n. Kidney trouble----------
Yes No o. Tuberculosis----------
Yes No p. Do you have a persistent cough or cough up blood?----------
Yes No q. Low blood pressure----------
Yes No r. Venereal disease----------
Yes No s. Epilepsy----------

Yes No t. Psychiatric problems----------
Yes No u. Cancer----------
Yes No v. AIDS or other immunosuppressive disorders----------
Yes No w. Other_____
Yes No 9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?----------
Yes No a. Do you bruise easily?----------
Yes No b. Have you ever required a blood transfusion?----------
If so, explain the circumstances _____
_____
Yes No 10. Do you have any blood disorder such as anemia?----------
Yes No 11. Have you ever had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?----------
Yes No 12. Are you taking any drug or medicine?----------
If so, what?_____
13. Are you taking any of the following:
Yes No a. Antibiotics or sulfa drugs----------
Yes No b. Anticoagulants (blood thinners)----------
Yes No c. Medicine for high blood pressure----------
Yes No d. Cortisone (steroids)----------
Yes No e. Tranquilizers----------
Yes No f. Antihistamines----------
Yes No g. Aspirin----------
Yes No h. Insulin, tolbutamide (Orinase) or similar drug----------
Yes No i. Digitalis or drugs for heart trouble----------
Yes No j. Nitroglycerin----------
Yes No k. Oral contraceptive or other hormonal therapy----------
Yes No l. Other_____
14. Are you allergic or have you reacted adversely to:
Yes No a. Local anesthetics----------
Yes No b. Penicillin or other antibiotics----------
Yes No c. Sulfa Drugs----------
Yes No d. Barbituates, sedatives, or sleeping pills----------
Yes No e. Aspirin----------
Yes No f. Iodine----------
Yes No g. Codeine or other narcotics----------
h. Other_____
Yes No 15. Have you had any serious trouble associated with any previous dental treatment?----------
If so, explain_____
_____
_____
Yes No 16. Do you have any disease, condition, or problem not listed above that you think I should know about?
If so, explain_____
_____
Yes No 17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?
Yes No 18. Are you wearing contact lenses?----------
Yes No 19. Have you had anything to eat or drink in the last 4 hours?----------
Yes No 20. Are you wearing removable dental appliances?----------

Women

Yes No 21. Are you pregnant?----------
Yes No 22. Do you have any problems associated with your menstrual period?----------
Yes No 23. Are you nursing?----------

Chief Dental Complaint:

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

_____
Signature of Patient Date

Policies

Financial Policy:

As a new patient you will be expected to pay what is estimated as your portion of your dental bill the day of your first appointment. This amount will be quoted to you to the best of our knowledge before treatment is started.

During treatment, there is the possibility that a diagnosis can be changed or made that will affect the amount estimated previously. In this case, a discussion will take place on how this additional cost will be paid and if full amount can be broken up into smaller increments.

Once established as a patient, our office may choose to extend a payment plan with no interest to help expedite any needed dentistry. A payment plan is not guaranteed to every patient. If you have been extended a payment plan but fail to follow through with your payment obligation, the full balance will be expected to be paid before the next statement cycle. The payment plan will decided by you and a front office staff verbally or in writing.

Failed Appointment:

If you fail three or more appointments without sufficient notice our office reserves the right to dismiss you from the practice. A dismissal will be determined by Dr. Graham and the office manager. If dismissed from the practice you will receive a written letter and we will extend our dental services to you for thirty days on an emergency only basis.

Cancellation Policy:

If you are not able to make your appointment, you need to cancel the appointment with a preferred 24 hour notice. Failing to do so could result in a "No Show Fee" being billed to you.

You may cancel appointments by calling (503) 644-9915 or by e-mail at kgraham@grahamclinic.com. Voicemail is available at all times and the e-mail is checked frequently. Please include your name, appointment date and time, and phone number so we can reschedule your appointment for a time that is more convenient to you.

No Show Fee:

The "No Show Fee" is applied at the discretion of the office manager and Dr. Graham. This fee is predominantly for patient's that frequently cancel with short notice or no notice at all and will not apply to every cancellation. Each incident will be evaluated at the time of occurrence.

If you do not cancel your appointment in advance and do not show up for your appointment you may be charged a "No Show Fee" which will be the cost of the scheduled appointment (varies with appointment length and procedure type-minimum charge will be $200 PER HOUR reserved).

If you cancel with less then 24 hours notice a fee of half the cost of the scheduled appointment will be assessed. (Minimum charge of $100 PER HOUR reserved).

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KATHERINE M. GRAHAM, D.M.D., P.C.

(NAME OF PRACTICE)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/01/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $ 45 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager

Telephone: 503 644-9915 Fax: 503 350-1275

E-mail: _____

Address: 12672 N.W. Barnes Rd., Ste. 101

Portland, OR 97229

KATHERINE M. GRAHAM, D.M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
Please Print Name

_____
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)_____

_____